



Joseph P Stapleton MD
Interventional Pain Management
Phone: 503-775-6500
Fax: 503-775-2275

Injection Referral Sheet

Request Date _____

Referring Physician _____

Patient Name _____ DOB _____

Home Phone _____ Work/Cell _____

Insurance Carrier _____

We are requesting:

() **Evaluation and Pain Management Procedure if appropriate.**

() _____

Please fax this form to:

503-775-2275

East Side Office

**9300 SE 91st Ave Suite 400
Portland, OR 97086**

West Side Office

**18650 NW Cornell Rd Ste. 212
Hillsboro, OR 97124**

Please fax: demographic sheet, copy of
insurance card, recent imaging studies, and most recent office notes.