



INTERVENTIONAL PAIN MANAGEMENT

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West Side Office

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REFERRING PROVIDER

Provider Name: _____

Date: _____ Phone: _____ Fax: _____

PATIENT INFORMATION

Last Name : _____ First Name: _____ MI: _____

DOB: _____ Home Phone: _____ Work/Cell: _____

Insurance Information: _____

WE ARE REQUESTING

- () Evaluation and Procedure if appropriate
- () Evaluation for Specific Procedure _____
- () Have Dr. Stapleton call me at this number to discuss: _____

Please fax: demographic sheet, copy of insurance card, recent imaging studies,
and most recent office notes to (503) 775-2275.

www.portlandpaincare.com

*Dr. Stapleton's office will secure prior authorizations.