OKLAHOMA
PAIN CENTER

REFERRAL FORM

Please fax this form along with patient demographics, lab work, MRI/CT/X-Ray reports, and the 3 most recent office notes to (405) 752-9650.

Referring Physician Information

Physician Name: _____

Phone: _____ Fax: _____

Physician to whom Patient is being Referred (Select One)

☐ Any Physician ☐ Dr. Kelly ☐ Dr. Lynch ☐ Dr. Marshall

Patient Information

Name: _____ DOB: _____

Insurance: _____ Phone: _____

Desired Treatment (Select One)

☐ Medication Management Body Part: _____

☐ Trigger Point Injection Body Part: _____

☐ Major Joint Injection Body Part: _____

☐ Epidural Injection Body Part: _____

☐ Lumbar Diagnostic/Therapeutic Medial Branch Nerve Block

☐ Lumbar Radiofrequency/Medial Branch Nerve Ablation

☐ Diagnostic Genicular Knee Injection

☐ Genicular Radiofrenquency Ablation

☐ Pain Pump Trial

☐ Spinal Cord Stimulator (SCS) Trial

☐ Other: _____

S. Blake Kelly, MD ● James Lynch, MD ● Jack Marshall, MD
Karie Stewart, APRN ● Stacy Torres, APRN ● Katherine Gaddis, APRN ● Jennifer McReynolds, PA-C ● Brandon S. Funk, PA-C
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