

PAIN MANAGEMENT EXAM REQUISITION

Attention: Dr. Evan Cohn



Patient Name: _____ Date of Birth: _____

Today's Date: _____

Patient Phone (Day): _____ (Eve): _____ (Cell): _____

Physician: _____ Phone: _____

Physician Signature: _____

Clinical Information/Diagnosis: _____

Appointment Date and Time: _____

SPECIAL REQUESTS

- Call physician w/appt time
- Fax physician w/appt time
- Call if patient reschedules or cancels
- Send copy of report to:
Dr. _____
PCP _____
- Physician contact number for urgent findings: _____
- After-hours/weekend #: _____

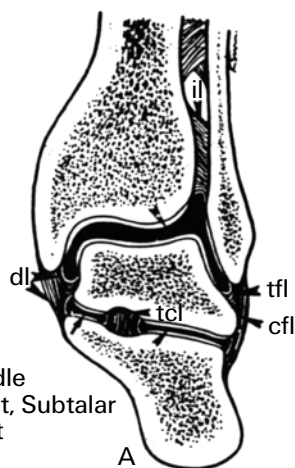
Injection Site:

- | | | | | | |
|-----------------------------|--------------------------------|-------------------------------|--------------------------------------|--------------------------------|-------------------------------|
| Shoulder: | <input type="checkbox"/> Right | <input type="checkbox"/> Left | Subacromial/Subdeltoid Bursa: | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Elbow: | <input type="checkbox"/> Right | <input type="checkbox"/> Left | Ankle (Please mark chart): | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Wrist: | <input type="checkbox"/> Right | <input type="checkbox"/> Left | Foot (Please mark chart): | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Hip: | <input type="checkbox"/> Right | <input type="checkbox"/> Left | Toe (Please mark chart): | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Greater Trochanteric Bursa: | <input type="checkbox"/> Right | <input type="checkbox"/> Left | SI Joint: | <input type="checkbox"/> Right | <input type="checkbox"/> Left |
| Knee: | <input type="checkbox"/> Right | <input type="checkbox"/> Left | Lumbar Facet Joint (Please specify): | | |
| | | | L1-2 L2-3 L3-4 L4-5 L5-S1 | <input type="checkbox"/> Right | <input type="checkbox"/> Left |

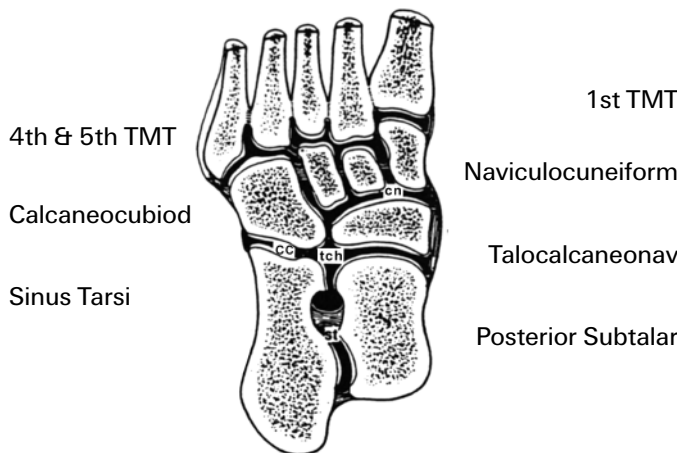
Tendon Sheath (Please Specify) _____

Other (Please Specify) _____

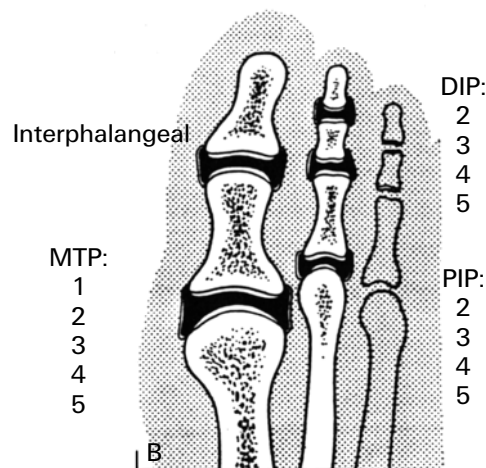
ANKLE:



FOOT:



TOE:



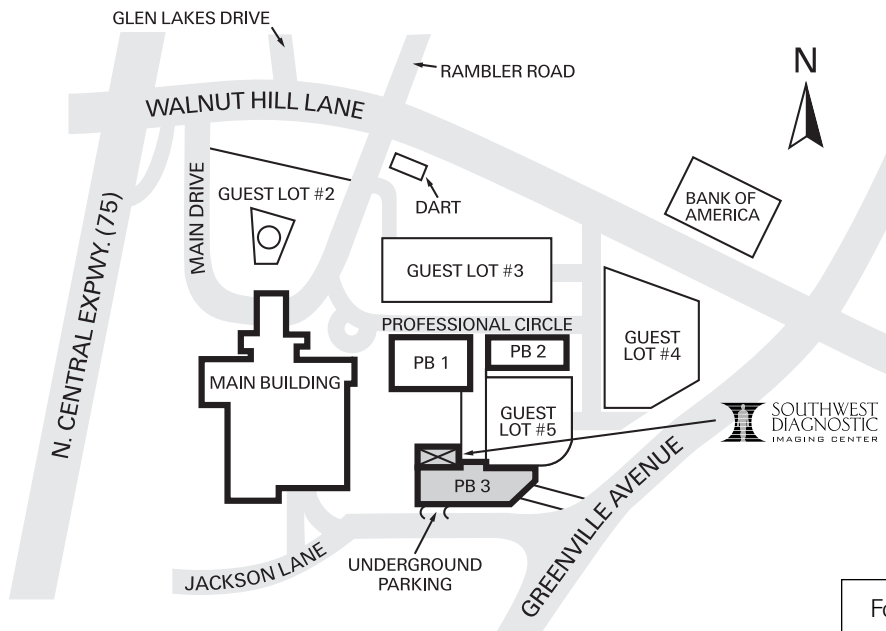
For any questions or further clarification, please contact Dr. Evan Cohn at 214/345-6905

FOR MAP, PLEASE SEE BACK OF FORM

Payment is required at the time of service unless other arrangements have been made.

WHITE – Patient Copy to Bring to SWDIC • YELLOW – Referring Physician's Office for Records.

Patients should arrive fifteen minutes prior to appointment time. Women during childbearing ages (12-55) SHOULD be screened for the possibility of PREGNANCY before scheduling Diagnostic, CT, and/or MRI procedures.



LOCATION:
Presbyterian Professional Building 3 (PB3)
8230 Walnut Hill Lane, Suite 100
Dallas, TX 75231-4472

PARKING:
Please park in lot #5 (open parking).
Parking validation will be provided.

Public Education Web site:
American College of Radiology
www.radiologyinfo.org

For additional Information visit
Southwest Diagnostic
Imaging Center's Web site.
www.swdic.com

IMAGING CENTER:
Phone 214/345-6905

SCHEDULING:
Phone 214/345-4331
Fax 214/345-6230