Cool Springs INTERVENTIONAL

Cool Springs Interventional
3310 Aspen Grove Drive, Suite 203
Franklin, TN 37067

To schedule an appointment, call
(615)-771-8274
(Open M-F 8 a.m. - 5 p.m.)
Fax: 615-771-8674

Appointment Information:

Day/Date

Time

Please arrive 15 minutes prior to your appointment time and bring:

- Insurance card(s)
- Photo ID
- List of Current Medications
- MRI Image CD (if available)
- Co-pay, co-insurance, or deductible due at time of service. Payment arrangement can be made.

Located in the clock tower building at SE Corner of Cool Springs Blvd West & Aspen Grove Dr.

Patient Referral Form
Diagnostic and Therapeutic Interventional Radiology

Patient Name: _____ Date of Birth:_____ Phone #_____

Primary Insurance:_____ Secondary Insurance:_____

Is the patient on Blood Thinners?? _____ if so, can they be off medication prior to procedure

Would you like CSI to obtain precert? YES / NO -> IF YES – PLEASE FAX US RELEVANT NOTES AND INFORMATION

PLEASE FAX ORDER, DEMOGRAPHIC, & INSURANCE INFO TO (615) 771-8674

Referring Physician:_____ ***Physician Signature:*** _____

Physician Phone #: (_____)_____ Physician Fax #: (_____)_____

Today's Date:_____ Diagnosis / ICD-10 Code(s):_____

PLEASE BE SPECIFIC - SUPPLY LOCATION (RT, LT, OR BILATERAL), THE SPINAL LEVEL & # OF INJECTIONS IF APPLICABLE

Epidural Steroid Injection :

- ☐ **Cervical – Level _____ x _____**
- ☐ **Thoracic - Level _____x _____**
- ☐ **Lumbar – Level _____ x _____**

Myelogram with Scheduled Post CT @ Premier / Cool Springs Imaging:

- ☐ **Cervical**
- ☐ **Thoracic**
- ☐ **Lumbar**
- ☐ **Complete**

Discogram with Post C.T.:

- ☐ **Lumbar Levels _____**

Trigger Point Injection:

- ☐ **Specify Location:**

Transforaminal Epidural Steroid Injection:

- ☐ **LUMBAR - Level_____x____**

Lumbar Puncture (LP):

- ☐ **Opening Pressure**
- ☐ **Diagnostic**
- ☐ **Therapeutic**

Kyphoplasty / Vertebroplasty Consult For Compression Fractures of Spine:

- ☐ **Consult - Please Send Studies - MRI Bone Scan, Bone Density, Notes**

Level (s) _____

- ☐ **Spine Biopsy – Fluoroscopic Guided**

Level _____ Send Available Studies

Facet Injection / Medial Branch Block:

- ☐ **Lumbar Level _____ x ___**

Radiofrequency Ablation

- ☐ **Lumbar Facet Joints**
- ☐ **Medial Branch Block Lumbar**

Joint Injections (specify location(s)):

- ☐ **Hip Steroid Injection**
- ☐ **Shoulder Arthogram**
- ☐ **Sacroiliac Joint Injection**
- ☐ **Trochanteric Hip**

Popliteal Cyst Aspiration / Ultrasound

- ☐ **Right Knee**
- ☐ **Left Knee**
- ☐ **Other**