



PREFERRED PROVIDER

- Kevin Andres, MD
 W. Blane Richardson, MD
 No Preference / First Available

PATIENT INFORMATION

Name _____ Date of birth _____
PATIENT FIRST PATIENT LAST MM/DD/YYYY

Home phone _____ Cell phone _____

Email address _____

PLEASE SUBMIT THE FOLLOWING WITH REFERRAL

Patient Demographics
 Last 3 Office Notes
 Imaging (if available)

Copy of Insurance Card, Workman's Comp Information, or Attorney Information

REFERRING PROVIDER INFORMATION

Name _____ Cell phone _____
PROVIDER FIRST PROVIDER LAST

Clinic/Hospital _____ Contact person _____

Clinic phone _____ Fax Number _____

Email address _____

PLAN OF CARE

Condition Evaluation

- | | | | |
|-----------------------------------|--------------------------------------|---|---|
| <input type="radio"/> Back Pain | <input type="radio"/> Neck Pain | <input type="radio"/> Arm or Leg Pain | <input type="radio"/> Head or Face Pain |
| <input type="radio"/> Joint Pain | <input type="radio"/> Nerve Pain | <input type="radio"/> Pelvic Pain | <input type="radio"/> Gluteal Pain |
| <input type="radio"/> Sacral Pain | <input type="radio"/> Abdominal Pain | <input type="radio"/> General Body Pain | <input type="radio"/> CRPS |
| <input type="radio"/> Other _____ | | | |

Treatment Consideration

- | | | | |
|--|--|--|--|
| <input type="radio"/> Epidural Steroid Injection | <input type="radio"/> Transforaminal ESI | <input type="radio"/> Medial Branch Block | <input type="radio"/> Occipital Nerve Block |
| <input type="radio"/> Peripheral Nerve Block | <input type="radio"/> Sympathetic Nerve Block | <input type="radio"/> Trigeminal Nerve Block | <input type="radio"/> Joint Injection |
| <input type="radio"/> Sacroiliac Joint Injection | <input type="radio"/> MILD Procedure | <input type="radio"/> Kyphoplasty | <input type="radio"/> Basivertebral Nerve Ablation |
| <input type="radio"/> Radiofrequency Ablation | <input type="radio"/> Sacroiliac Joint Fusion | <input type="radio"/> Intrathecal Pain Pump | <input type="radio"/> Spinal Cord Stimulation |
| <input type="radio"/> DRG Stimulation | <input type="radio"/> Peripheral Nerve Stimulation (PNS) | | |
| <input type="radio"/> Other _____ | | | |

Physician Signature _____ Date _____

CLINIC LOCATIONS

With clinics in Louisville and Elizabethtown plus an accredited, onsite surgery center in St. Matthews, your patients have convenient access to expert pain care and a full range of treatment options.



EAST LOUISVILLE CLINIC

6400 New Dutchmans Pkwy
Suite #60
Louisville, KY 40205
phone: 502-791-8700
fax: 888-241-7991

Providers at this location:

Kevin Andres, MD
W. Blane Richardson, MD

ELIZABETHTOWN CLINIC

2407 Ring Road
Suite #135
Elizabethtown, KY 42701
phone: 502-791-8700
fax: 888-241-7991

Providers at this location:

Kevin Andres, MD
W. Blane Richardson, MD

SOUTH LOUISVILLE CLINIC

6801 Dixie Highway
Suite #135
Louisville, KY 40258
phone: 502-791-8700
fax: 888-241-7991

Providers at this location:

Kevin Andres, MD
W. Blane Richardson, MD

THANK YOU FOR REFERRING YOUR PATIENTS TO CAPITOL PAIN!

