Boston Scientific
Advancing science for life™

Patient Referral Form for Interventional Pain Evaluation

Patient Name:_____ Patient Zip Code: _____

Patient DOB: _____Patient Telephone: _____

Patient Insurance:_____

Patient opt-in: I authorize a Boston Scientific representative to educate me on Boston Scientific pain therapies:

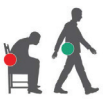
Patient Signature: _____

Name of Interventional Pain Doctor: _____

Please indicate the kind(s) of pain your patient is experiencing:

☐ Pain in the back, knees, or feet from any of the following conditions:

- Failed back surgery syndrome
- Radiculopathy
- Diabetic peripheral neuropathy
- Complex regional pain syndrome
- Non-surgical back pain



☐ Chronic low back pain that worsens with sitting and improves with walking
Vertebrogenic chronic low back pain

☐ Back pain that worsens with twisting and improves with sitting
Facetogenic/joint pain

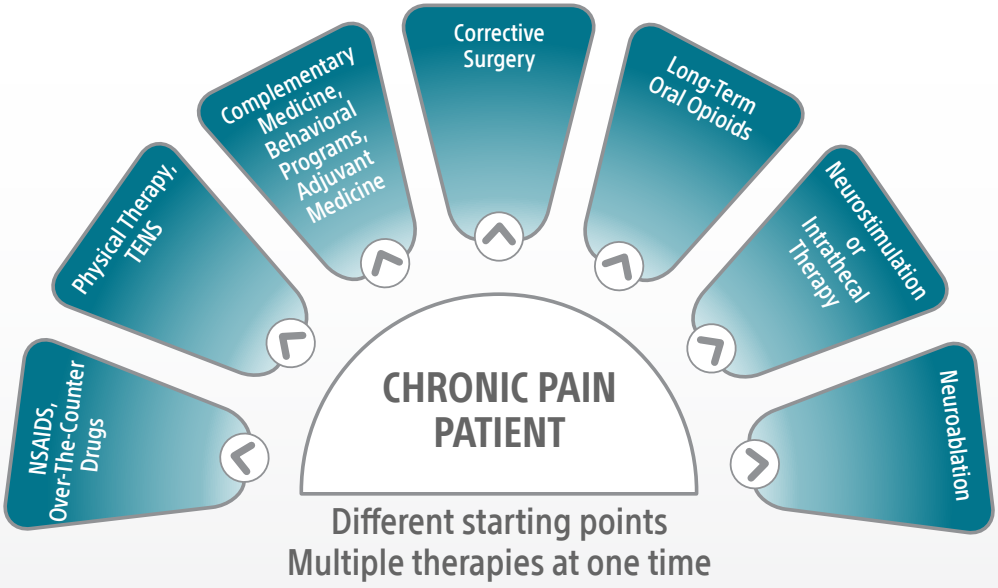
☐ Other (Please describe):_____

_____

REFERRING PROVIDER INFORMATION

Referrer Name:_____

Referrer Telephone: _____



Different starting points
Multiple therapies at one time

To learn more about the programs and resources Boston Scientific provides to help support your patients, visit BostonScientific.com/Liaison.

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