



PAIN MANAGEMENT PROCEDURE QUESTIONNAIRE

NAME: _____ POLICY NO: _____

Please check either "YES" or "NO" for every procedure to indicate whether you plan to perform any of the following procedures in your current practice:

ACUPUNCTURE	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
BLOCKS:				
CAUDAL EPIDURAL BLOCK	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
CELIAC PLEXUS BLOCK	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
CERVICAL EPIDURAL	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
DIFFERENTIAL SPINAL	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
FACET JOINT BLOCK:				
CERVICAL	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
LUMBAR	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
THORACIC	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
LUMBAR EPIDURAL	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
LUMBAR SYMPATHETIC BLOCK	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
PERIPHERAL NERVE BLOCK	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
RETROBULBAR BLOCK	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
SPINAL NERVE BLOCK	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
STELLATE GANGLION BLOCK	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
SYMPATHETIC NERVE BLOCK	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
BOTOX INJECTIONS	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
CERVICAL DISCOGRAMS	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
CERVICAL DISC NUCLEOPLASTY	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
CORDOTOMIES	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
CRYOANALGESIA	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
DORSAL COLUMN STIMULATOR IMPLANTS/REPROGRAM	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
EPIDURAL OR SPINAL CATHETERS	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
FLUOROSCOPY	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

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| INTRA-ARTICULAR BLOCK (JOINT INJECTIONS) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| INTRADISCAL ELECTROTHERMAL THERAPY | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| INTRAVENOUS REGIONAL ANESTHESIA | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| HYPNOSIS | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| LUMBAR DISCOGRAMS | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| LUMBAR DISC NUCLEOPLASTY | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| MANIPULATION & MASSAGE | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| MYOFASCIAL TRIGGER POINT INJECTIONS | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| NERVE ROOT INJECTIONS | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| PERCUTANEOUS DISCECTOMY | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| PERCUTANEOUS ENDOSCOPIC NERVE ROOT DECOMPRESSION | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| PERIPHERAL NERVE STIMULATION | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| PHYSICAL THERAPY | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| PROLOTHERAPY | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| If "YES", do you use Phenol? | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| RADIO FREQUENCY NERVE ABLATION | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| RAPID DETOXIFICATION | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| SPHENOPALATINE LESIONING | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| SPINAL INFUSION IMPLANTS OR REMOVAL | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| SPINAL INFUSION PUMPS REFILLING & REPROGRAMMING | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| SPINAL STIMULATION IMPLANTS | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| SPINAL STIMULATION PROGRAMMING | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| THORACIC SYMPATHECTOMIES | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| TRIGEMINAL LESIONING | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| VERTEBROPLASTY | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

What percentage of your practice incorporates the procedures above? _____

Where (which locations) is the insured practicing this type of surgery? _____

Please list other procedures you perform that are not listed above:

Please provide proof of training/certification with an approved anesthesia program to the procedures that you have indicated above.

Signature _____ Date: _____