



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: _____