



PIEDMONT
Interventional
PAIN CARE, PA

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Date: _____

Referring Physician: _____

Primary Care Physician: _____

Patient Name: _____

SS#: _____

Patient Address: _____

Phone: _____ Birthdate: _____ Male Female

Primary Insurance: _____

Policy Holder: _____ DOB: _____ Employer: _____

Claim Address: _____ Phone Number: _____

ID Number: _____ Group Number: _____

Secondary Insurance: _____

Policy Holder: _____ DOB: _____ Employer: _____

Claim Address: _____ Phone Number: _____

ID Number: _____ Group Number: _____

Patient is Referred for:

Myofascial pain (muscle pain)

Lumbar facet arthropathy (low back joint pain)

Cervical facet arthropathy (neck joint pain)

Lumbar degenerative disc disease

Cervical degenerative disc disease

Back and leg pain

Neck, shoulder and arm pain

Sciatica (radicular pain)

Occipital headaches

Shingles (herpes zoster) pain

Thoracic facet arthropathy (back joint pain)

Complex regional pain syndrome (CRPS)

Thoracic degenerative disc disease

Reflex sympathetic dystrophy (RDS)

Indicate Procedure (if applicable) _____

Cancer Pain

Other (explain) _____

- Please fax all medical records, radiology reports and insurance card
- Please send insurance referral if required
- Omitted information will delay our ability to respond to your request promptly
- We will fax the appointment back to you to advise your patient

Office Hours: M-Th: 7:30 am - 5:00 pm; F: 7:30 am - 2:00 pm