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PHYSICIAN REFERRAL FORM

Date: _____/_____/_____
Patient Name:_________________________ SSN:______-______-______ DOB: ____/_____/_____

Telephone: _________________ Sex: ☐M ☐F Weight ________ Height _______ Age _____
Address: _______________________________________ Insurance _________________________________

Referring Physician: _________________________________ Phone: ______________ Fax: ___________
Referring Diagnosis: ____
Previous surgeries / Procedures (please include dates): ____
____
____

Please Provide us with the following information:

- **Pertinent medical records including any MRI, CT scan or X-ray reports**
- **If possible, copy of the patient's current medical insurance card(s) – front & back**
- **Does the patient have any specific allergies?** ____
- **If the patient is on blood thinners and is being scheduled for a procedure, do they have clearance to be off the blood thinner (five days for Coumadin, seven days for Plavix) prior to procedure date?**
- **The patient consents to a fluoroscopic procedure and is not pregnant at this time.**

Consults Requested (please check all that apply)

☐Pain Provider to Evaluate and Determine Procedure and Level

☐Procedure Only ☐Consulting Appointment and Return to Referring Provider

Diagnostic Injections

Discography
- □ Lumbar Levels: _______

Selective Nerve Root Block
- □ Cervical: _________
- □ Thoracic: _________
- □ Lumbar Levels: _______

Facet Nerve Injection
(Medial Branch Blocks)
- □ Cervical: _________
- □ Thoracic: _________
- □ Lumbar Levels: ______

Therapeutic Injection

Epidural Steroid Injection
- □ Cervical: _________
- □ Thoracic: _________
- □ Lumbar Levels: ______

Facet Joint Steroid Injection
- □ Cervical: _________
- □ Thoracic: _________
- □ Lumbar Levels: ______

Sympathetic Block
- □ Stellate □ Lumbar
- □ Celiac □ Hypogastric
- □ Ganglion Impar

Therapeutic Injection Cont..

□ Sacroiliac / Hip / Knee Injection
(L R Bilateral)

□ Trigeminal Ganglion Block
(L R Bilateral)

□ Peripheral Nerve Block
(L R Bilateral)

□ Radiofrequency Ablation
(Rhizotomy) Level: _______

Implantable Trials

□ Spinal Cord Stimulator

□ **Other** __________________