



REFERRAL FAX / REQUEST

PATIENT INFORMATION **REFERRING PHYSICIAN INFORMATION**

| | |
|-------------------------|-------------------------|
| Name: _____ | Physician: _____ |
| Home Ph#: _____ | Specialty: _____ |
| Cell# _____ | Office Ph# _____ |
| SS# _____ | NPI# _____ |
| DOB: _____ | Apt. Date & Time _____ |
| Insurance Policy# _____ | Precert/Referral# _____ |

- Primary/ Medical Care Pain Management Chiropractic Care Neurology

Diagnosis/ Problem (Circle all that applies to the Patient)

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|---------------|-------------------|------------------------|
| Work Injury | Back Pin | Fibromyalgia |
| Sports Injury | Arm / Elbow Pain | Muscle Pain / Weakness |
| Chronic Pain | Shoulder Pain | Headaches / Miigraine |
| Knee Pain | Ankle /Foot Pain | Arthritis |
| Hip Pain | Phantom Limb Pain | Disc Herniation |
| Wrist Pain | Sciatica/Leg Pain | Neck Pain |

Other: _____

Injections

- Epidural Steroid Injections
- Facet Joint
- Major Joint
- Medial Branch Nerve Blocks
- Radio Frequency Ablations
- Botox Injections
- Spinal Steroid
- Spinal Cord Stimulation Trials

Procedures

- Sympathetic Blocks
- Sphenopalatine Ganglion Blocks
- Stellate Ganglion Block
- Occipital Nerve Blocks
- Discography / Intradiscal Injections
- Phantom Limb Treatment
- Triger Point Injections
- Concussion
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