PATIENT REFERRAL FORM

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Patient Name: ________________________________ **Date:** ______________________

Referring Physician: ____

Phone: ____________________ **Fax:** ________________________

Please indicate level of service requested:

☐ Evaluate and Treat if necessary

☐ Consultation Only

☐ Epidural Steroid Injection*

☐ Discogram*

☐ Transforaminal Steroid Injection*
Level: _______________

☐ Facet Joint Injection*

☐ Sacroiliac Joint Injection*

☐ Trigger Point Injection*

☐ OTHER: ___________________________________

COMMENTS:

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*When referring for procedure only, your patient will be scheduled with the first available physician in the procedure room for their initial injection. No office consultation/evaluation will be performed.

To expedite your referral, please include patient's demographic information, insurance information, radiology reports and recent medical records.

THANK YOU!