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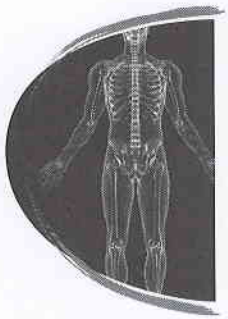

FAX REFERRAL

Name: _____ Date: _____

DOB: _____ Home Phone #: _____ Work Phone #: _____

Chief Complaint/Diagnosis: _____

_____

*** PLEASE FAX COPIES OF ANY DIAGNOSTIC REPORTS (MRI, CT, X-RAY, ETC.), AS WELL AS THE MOST RECENT PHYSICIAN'S NOTES, PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION RELATED TO THE PATIENT ALONG WITH THIS REQUEST FORM. ***

- ❑ Pain Evaluation & Consultation
- ❑ Diagnostic Nerve Block
- ❑ Epidural Steroid Injection
  ___cervical ___thoracic ___lumbar
- ❑ Facet Joint Injection
  ___cervical___thoracic___lumbar
- ❑ Selective Nerve Root Block
  ___cervical___thoracic___lumbar
- ❑ Discography
  ___thoracic___lumbar
- ❑ Botox Treatment for Maxillofacial Pain, Migraines and TMJ
- ❑ Specific Level Desired (If applicable): _____

OTHER: _____

- ❑ Nucleoplasty (Percutaneous)
- ❑ IDET Procedure
- ❑ Lumbar Sympathetic Block
- ❑ Occipital Nerve Block
- ❑ Stellate Ganglion Block
- ❑ Trial Spinal Cord Stimulator
- ❑ Facet Rhizotomy
- ❑ Intrathecal Pump/Trial/Refill
  ___Morphine ___Baclofen ___other
- ❑ EMG / NCV (electromyogram and nerve conduction studies)

Referring Physician: _____ Contact Telephone: _____