



Patient Referral Form

PATIENT'S NAME:		Male	Female	D.O.B
Home Phone:	Work Phone:			Cell Phone:
	Extension:			
INSURANCE		POLICY NUMBER		
DIAGNOSIS:				ICD:
REFERRING MD:		Office:	Fax:	
CONTACT PERSON:				

<u>CONSULTATION, TESTING & TREATMENT</u>	
FAX: 757-422-4563	PHONE: 757-422-2966

Physiatry Consultation/Treatment
 Migraine Consultation
 Physical Therapy

EMG/NCS: Area: _____
 Botox Injection: Area: _____
 Other: : _____

<u>PROCEDURES ONLY:</u>	
<i>(Patient does NOT require prior consultation)</i>	
FAX: 757-422-4563	PHONE: 757-422-2966
757-351-6035 - MD Line	

Epidural Steroid Injection Only: Area: _____
 Facet Joint Injection: Area: _____
 Diagnostic Medical Branch Block Area: _____
 Radiofrequency Denervation (Requires previous diagnostic blocks): Area: _____
 Joint Injection: Area: _____
 Fluoroscopically Guided Prolotherapy Injections: Area: _____
 Lumbar Sympathetic Block
 Lumbar Discography
 Spinal Cord Stimulator TRIAL: _____

PLEASE ATTACH THE FOLLOWING INFORMATION

- Referral, if required
- Copy of insurance card/WC claim information
- Patient Demographics
- Recent Office Notes
- MRI/CT Report (Mandatory for all procedures)

We DO NOT participate in the following insurances:

- United Health Care
- Tricare Prime
- North Carolina Medicaid
- Optima Family Care
- Anthem Healthcare Plus
- MAMSI
- PHCS

FOR APM USE ONLY:

Appointment Date: _____ Time: _____ DR: _____ Location: _____ <input type="checkbox"/> Attempted to contact patient 3 times with NO RESPONSE <input type="checkbox"/> Patient refused treatment <input type="checkbox"/> Not scheduled after medical review
