

## 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:				

### CONSULTATION, TESTING & TREATMENT

**FAX: 757-422-4563      PHONE: 757-422-2966**

Physiatry Consultation/Treatment  
Migraine Consultation  
Physical Therapy

EMG/NCS: Area: \_\_\_\_\_  
Botox Injection: Area: \_\_\_\_\_  
Other: : \_\_\_\_\_

### PROCEDURES ONLY:

*(Patient does NOT require prior consultation)*

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

#### 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	