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REFERRAL FORM

To expedite your patient's encounter with us:

1. **Fax recent physician's notes**
2. **Fax applicable radiology reports**
3. **Include insurance & demographic information**

This form can also be found on our website: www.ParkerPainMD.com/for-referring-physicians.html

Patient

PATIENT NAME:____DATE: ______________________________

CELL #: ___________________ HOME PHONE #: ____________________ WORK PHONE #:__________________

DOB:___________________

PATIENT ADDRESS:_________________________________ CITY, STATE, ZIP:______________________________

PRIMARY INSURANCE:_____________________________________ PHONE #:______________________________

POLICY ID#:_________________________ GROUP #:_________________________

☐ Patient needs to be seen ASAP ☐ Contact Patient ☐ Patient will contact Parker Pain & Spine

Referring Provider

REFERRING PROVIDER:____ PHONE:_________________________

FAX:______________________________________ CONTACT PERSON:___________________________________

CHIEF COMPLAINT/DIAGNOSIS:____

Therapy Requested

- ☐ PAIN EVALUATION/CONSULTATION
- ☐ EVAL FOR SPINAL CORD STIMULATOR
- ☐ EPIDURAL STEROID INJECTION __________________ (location)
- ☐ DISCOGRAM ________________________________(location)
- ☐ EVAL FOR VERTEBRAL COMPRESSION FRACTURES _________________(location)
- ☐ NERVE BLOCK ____(location)
- ☐ FACET JOINT PROCEDURE __________________ (location)
- ☐ OTHER:

Notes from Referring Provider