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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.\***

- |   |   |
|---|---|
| <input type="checkbox"/> Caudal Steroid Injection<br>Cervical ___ Thoracic ___ Lumbar ___   | <input type="checkbox"/> Caudal Lysis of Adhesions              |
| <input type="checkbox"/> Epidural Steroid Injection<br>Cervical ___ Thoracic ___ Lumbar ___ | <input type="checkbox"/> Sacroiliac Joint Steroid Injection     |
| <input type="checkbox"/> Discography<br>Cervical ___ Thoracic ___ Lumbar ___                | <input type="checkbox"/> Spinal Cord Stimulator Trial / Implant |
| <input type="checkbox"/> Facet Joint Injections<br>Cervical ___ Thoracic ___ Lumbar ___     | <input type="checkbox"/> Stellate Ganglion Block                |
| <input type="checkbox"/> Lumbar Sympathetic Block   | <input type="checkbox"/> Trigger Point Injections               |
| <input type="checkbox"/> Transforaminal Epidural Steroid injections<br>Lumbar: Levels _____ | <input type="checkbox"/> Vertebroplasty                         |
| Hip _____, Knee _____ Shoulder _____  | <input type="checkbox"/> Joint Injections                       |
|   | <input type="checkbox"/> OTHER: _____                           |

Referring Physician: \_\_\_\_\_ Contact Telephone: \_\_\_\_\_