PAIN SPINE & REHAB ASSOCIATES
Put Your Life Back Together

501 North Frederick Avenue
Suite 302
Gaithersburg, MD 20877

18111 Prince Phillip Drive
Suite 121
Olney, MD 20832

Tel 301.591.8261
Fax 301.591.8262
www.painspineandrehab.com

PRACTITIONER REFERRAL FORM

****In order to expedite scheduling, please include insurance information and attach member ID card (both sides) & fax last 6 months of pertinent progress/procedure notes, current list of medications and relevant diagnostic studies****

REFER to ☐ Mohsin Sheikh, M.D. ☐ Kristin Petronio, PA-C ☐ First Available

Date of Referral_____Type _____ Routine _____Urgent _____Emergency (must call)

Patient Name_____DOB: ___ / ___ / _____ Best contact# ( )_____-_____

Insurance_____Pre-Cert required? Yes_____No_____

Member ID#: _____Group Number _____

Requested By: _____ _____NPI Number _____

Address_____Phone ( )_____-_____Fax ( )_____-_____

Reason for referral/Possible diagnoses: _____

[All electrodiagnostic studies are performed by Dr. Sheikh, unless otherwise indicated**]**

TYPE OF CONSULTATION REQUESTED

☐ New Patient Evaluation & Treatment
☐ Consultation Only (Medical opinion/recommendations)
☐ 2nd Opinion

Specific Procedure Request [*scheduled separately, after initial visit*]

- ☐ Epidural steroid injection/selective nerve root block
- ☐ Facet/medial branch block/radiofrequency denervation
- ☐ Sacroiliac joint injection/radiofrequency denervation
- ☐ Trigger point injections and/or dry needling
- ☐ Peripheral nerve _____or joint/bursa injection _____
- ☐ Spinal cord stimulator trial
- ☐ Botulinum Toxin for chronic migraine
- ☐ Other_____(please call or be specific)

ELECTRODIAGNOSTICS
Right / Left / Bilateral
Upper / Lower / Both
r/o _____

MSK ULTRASOUND
☐ Diagnostic only
☐ with Injection
r/o_____

☐ FAST TRACK (same day consult and procedure ONLY if allowed by insurance and NO medical contra-indications)

In order to ensure that we prescribe safely and responsibly, we cannot guarantee assumption of medication management at the initial visit. Please contact us in advance if you anticipate special medication requirements.

PLEASE PROVIDE REFERRAL OR INFORM PATIENT TO OBTAIN REFERRAL IF NEEDED

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