REFERRAL FORM

Southern Interventional Pain Center

Max Shokat, D.O.

DATE_____

REFERRING PROVIDER_____ NPI# _____

PHONE_____ FAX _____

PATIENT NAME (first and last) _____ DATE OF BIRTH _____

PATIENT HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PATIENT'S INSURANCE _____ SUBSCRIBER ID _____

PATIENT'S PCP _____ PCP PHONE NUMBER _____

PATIENT DIAGNOSIS _____

REFERRAL TYPE

☐ **Consult and Treat** ☐ **Consult and Return** ☐ **Procedure Only**

In order to help us provide your patient with the best possible care, please fax the following:

- Completed Referral Form
- Legible copies of patient's insurance cards (both sides)
- Most recent clinical/progress note pertaining to pain condition
- List of current medications
- Current diagnostic testing work-up and radiology reports on patient

PLEASE FAX THIS FORM TO 855-313-1262

PHYSICIAN SIGNATURE _____

DATE _____

PROCEDURES

- ☐ Epidural Steroid Injection (Cervical, Thoracic, Lumbar, Caudal)
- ☐ Selective Nerve Root Block (Cervical, Thoracic, Lumbar, Sacral)
- ☐ Facet Joint Injection (Cervical, Thoracic, Lumbar)
- ☐ Radiofrequency Lesion (Cervical, Thoracic, Lumbar, Sacroiliac Joint)
- ☐ Joint injection: Specify _____
- ☐ Sacroiliac Joint Injection
- ☐ Tendon Sheath Injection: Specify _____
- ☐ Bursa injection: Specify _____
- ☐ Viscosupplementation Injections for Knee Osteoarthritis
- ☐ Sympathetic Nerve Block: Stellate Ganglion, Lumbar, Other _____
- ☐ Peripheral Nerve Block: Specify _____
- ☐ Spinal Cord Stimulation
- ☐ Vertebroplasty/Kyphoplasty
- ☐ Chemodenervation (Botox®) for Chronic Migraine
- ☐ Pulsed Radiofrequency Lesion: Specify _____
- ☐ Chemical Neurolysis: Specify _____
- ☐ Peripheral Nerve Stimulation: Specify _____
- ☐ Regenerative Therapy Including Prolotherapy, Platelet Rich Plasma and Stem Cell Injections: Specify _____
- ☐ Biacuplasty
- ☐ Other _____

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sipaincenter.com