REFERRAL FORM

Southern Interventional
Pain Center

Max S. Shokat, D.O. • Margaret C. Boltja, M.D.

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

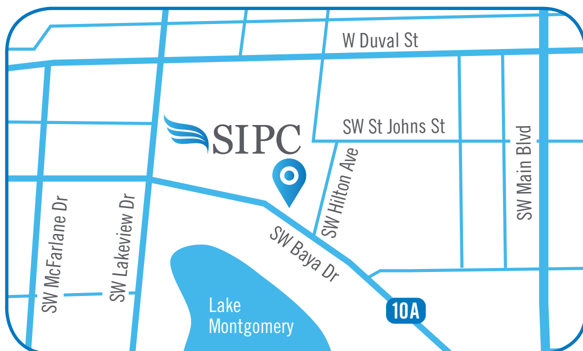
☐ **Pain Management** **(or)** ☐ **Neuro Eval/Treat**

☐ **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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