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

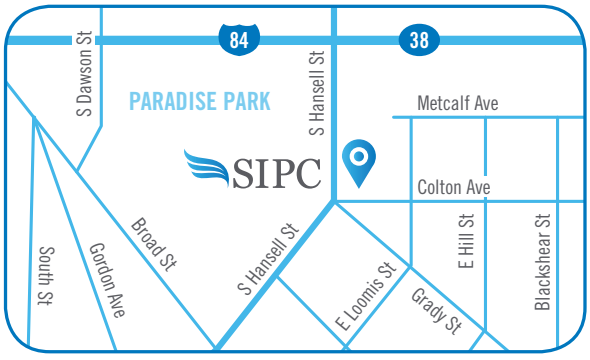
☐ **Pain Management (or)** ☐ **Neurology**

☐ **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 229-226-2237



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 _____