SPINAL DIAGNOSTICS

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NEW PATIENT REFERRAL FORM

Name _____ Date of Birth _____ Patient Phone _____

Diagnosis _____

Referring Practitioner _____

Patient to See: *(leave blank for 1st available)*

- ❑ Dr. Heros
- ❑ Dr. Anderson
- ❑ Tyler Huntington, PA-C
- ❑ Debora Mitchell, FNP-C

Service Requested:

- ❑ Comprehensive Spine Evaluation / Office Consultation
- ❑ Evaluate for Spinal Cord Stimulation/DRG Trial
- ❑ Evaluate for Pelvic Pain(*Dr. Heros only*)
- ❑ Evaluate and treat PTSD *(Dr. Anderson only, to consider stellate ganglion block)*
- ❑ Request for Intervention under Monitored Anesthesia Care:

  Level(s) _____

  - ❑ Epidural Steroid Injection
  - ❑ Facet Joint Injection
  - ❑ Diagnostic Facet Block / RFA
  - ❑ Sacroiliac Joint Inject
  - ❑ Diagnostic Only
  - ❑ Therapeutic Injection
  - ❑ Other _____

REFERRING OFFICE: PLEASE INCLUDE PATIENT DEMOGRAPHICS, INSURANCE INFORMATION, RECENT CHART NOTES, ANY SPINAL IMAGING REPORTS AND INSURANCE AUTHORIZATION # IF REQUIRED

Signature _____ Date _____