

VALLEY MEDICAL PATIENT REFERRAL FORM

Please Fax Form to 612-444-9000

Please complete **ALL** sections of this form. Your patient will receive a call within 24-48hrs to schedule a consultation.

Patient Details

Patient Name: _____ Date of Birth: _____
Mobile Phone: _____ Sex: Male Female Race/Ethnicity: _____
Address: _____
Patient Email Address: _____
Insurance Carrier: _____ Insurance ID No: _____

Referral Details

Reason for referral / primary diagnosis: _____

Consultation Only

Evaluate and Treat:

- Manage chronic pain medications Substance Abuse Services (e.g., alcohol, BZDs)
 Opioid Dependence Neck pain Back pain Headaches Fibromyalgia
 Other: _____

Evaluate and Consider:

- Trigger Point Injections Prolotherapy
 Viscosupplementation (Hyaluronic acid) Large Joint Steroid Injection
 Sacroiliac Joint Injection Suprascapular Nerve Block
 Botox (Cervical Dystonia/Chronic Migraine) Supraorbital Nerve Block
 Dorsal Digital Nerve Block (Morton's Neuroma)
 Other: _____

Please include 3-6 months of past medical records and any relevant pathology and imaging results with this referral. This information will assist us in appropriately triaging your patient.

Medical Records Included: 3 months 6 months Other:

Additional Comments: _____

Referring Physician

Referring Provider Name: _____ Mobile Phone: _____

Referring Provider Clinic: _____ Clinic Phone: _____

Clinic Fax Number: _____

Follow up reports should be faxed to referring provider: As needed Every Visit Other: _____