valley medical & wellness
Burnsville | Minneapolis | Woodbury | Rochester | Bemidji | Plymouth
Mailing Address: 2428 East 117th Street Burnsville, MN 55337
Phone: 612-444-3000 | Fax: 612-444-9000

REFERRAL FORM

Please Fax Form to 612-444-9000

Please complete all sections of this form. Your patient will receive a phone call to scheduled appointment.

Patient Details

Patient Name:_____

Date of Birth:_____ Patient Phone: _____ Sex: ☐ Male ☐ Female

Patient 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, opioids)
- ☐ 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 6-12 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: ☐ 6 months ☐ 12 months ☐ Other_____

Additional Comments: _____

_____

_____

Referring Physician

Provider Name: _____ Clinic Name: _____

Phone Number: _____ Fax Number: _____

Provider's signature: _____ Date: _____