SPINAL DIAGNOSTICS

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NEW PATIENT REFERRAL FORM

Name _____ Date of Birth _____ Patient Phone _____

Diagnosis _____

Referring Practitioner _____

PCP (if different) _____

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

❑ Dr. Robert Heros ❑ Dr. Jason Anderson ❑ Lindsay Purtell, PA

Service Requested:

- ❑ Comprehensive Spine Evaluation / Office Consultation
- ❑ Evaluate for Spinal Cord Stimulation Trial
- ❑ 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
- ❑ Other _____

❑ Diagnostic Only
❑ Therapeutic Injection

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

Signature _____ Date _____