

Date of Referral _____

Referring Physician Name _____

Referring Physician Phone Number _____

Patient Information

Name _____ Date of Birth _____

Phone (Home) _____ (Work) _____ (Cell) _____

Brief History

Diagnosis _____

Symptoms _____

Reason For Referral

_____ Evaluation Only (*Recommendations for management only*)

_____ Evaluation and Treatment

_____ Procedure: (*Please circle and/or specify if able*) _____

Epidural Steroid Injection

Transforaminal Epidural Steroid Injection

Selective Nerve Root Block

Facet Injection

Medial Branch Block

Radiofrequency Ablation

Sacroiliac Joint Injection

Lumbar Discography

Stellate Ganglion Block

Lumbar Sympathetic Block

Occipital Nerve Block

Joint Injection

Trigger Point Injection

Spinal Cord Stimulator Trial

Other

Please fax the following information, if available:

A copy of the patient's insurance card and demographics

A copy of any diagnostic imaging reports (CT/MRI) specific to the pain problem

A copy of the H&P and most recent clinical note

Please fax referral and additional information to (770) 790-4811

Thank you for allowing Atlanta Pain and Spine Physicians to participate in your patient's care!