UNITED SPINE AND ORTHO

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Date: _____ **Patient Referral Form** Referred By: _____

Patient Information:

Patient Name: _____ D.O.B. _____ Phone: _____

Address: _____ Email: _____

Reason for Visit: _____

Payor Source:

☐ Personal Injury ☐ Worker's Comp ☐ Medicaid ☐ Medicare ☐ Self-Pay ☐ Private Insurance

Policy/Claim Information: _____

Attorney (if applicable):

Name: _____ Law Firm: _____

Email: _____ Phone: _____ Fax: _____

Policy Limits: _____ Case Manager: _____

Evaluate and Treatment: ☐ Bilateral ☐ Left ☐ Right

☐ Neck ☐ Upper Back ☐ Mid Back ☐ Lower back ☐ Shoulder ☐ Hip ☐ Knee

☐ Leg ☐ Arm ☐ Headaches ☐ Other:

Evaluate and Consider:

☐ Epidural Steroid Injection ☐ Lumbar Transforaminal Epidural ☐ Sacroiliac Joint Injection

☐ Facet Joint Injection ☐ Medial Branch Block ☐ Lumbar Sympathetic Block ☐ Trigger Point Injections

☐ EMG/Nerve Conduction Study ☐ Radiofrequency Nerve Ablation ☐ Independent Medical Evaluation

☐ Other:

X-Ray Performed?: ☐ Yes ☐ No If yes, specify: _____

CT/MRI Performed?: ☐ Yes ☐ No If yes, specify: _____

Physical Therapy?: ☐ Yes ☐ No If yes, specify: _____

Additional Comments: _____

PLEASE FAX ANY OFFICE NOTES AND DIAGNOSTIC REPORTS RELATED TO THE VISIT ALONG WITH REQUEST FORM

552 Ponce de Leon Ave. NE, Atlanta, Georgia 30308