Provider Referral Form

FAX TO: 770-516-7870

Referring Provider: ____

Office Contact: ________________________Contact #:____________________

☐ **Urgent Visit** ☐ **Non-Urgent Visit**

Patient Name: ____________________________ DOB:__________________

Address: ________________________________ City:___________________

Cell #:__________________________Home #:_________________________

Is this a WC referral? Yes / No

Claim #:__________Case Manager:_________________Phone #:_______________

PLEASE SEND THE FOLLOWING INFORMATION:

1. Demographic sheet
2. Front and back of insurance cards
3. Any imaging reports (MRI, CT, X-Ray)
4. 1-3 recent office notes
5. List of current medications

DX:

☐ Neck Pain
☐ Cervical / Thoracic Spondylosis
☐ Low Back Pain
☐ Lumbar Spondylosis
☐ Lumbar Radiculopathy
☐ Thoracic Pain
☐ Sacroiliac Joint Pain
☐ Compression Fx
☐ Diabetic Neuropathy
☐ Spinal Cord Injury Nerve Pain
☐ Other__________________

REFERRAL FOR:

☐ Evaluation & Treatment

☐ Consultation and Report ONLY

☐ Epidural Injections

☐ Sacroiliac Injections / Radiofrequency Therapy

☐ Facet Injections / Radiofrequency Therapy

☐ Spinal Cord Stimulator Evaluation / Trial

NOTES:____

Has patient had prior pain management? ☐ Yes ☐ No

If yes, with who? ____

Woodstock Office:
240 Heritage Walk
Woodstock, Georgia 30188

Jasper Office:
49 Gordon Rd
Jasper, Georgia 30143

Acworth Office:
3950 Cobb Pkwy. NW, STE 101
Acworth, Georgia 3010