PAIN SPINE CENTER
NORTH FULTON HOSPITAL

Physician Referral Request

Medical Plaza • 4500 Hospital Blvd, Suite 200 • Roswell, GA • 30076 • Phone (770) 751-2719 • Fax (770) 751-2609

Please fax to 770-751-2609. Include copy of Medical Notes, Imaging Reports, and Insurance Card

DATE: ______________________ ☐ New Patient ☐ Established Patient

PATIENT ______________________ DOB ______________ SSN ______________________

Address ____

Phone # ______________________ Alt Phone # ______________________

Insurance Company ______________________ ID# ______________________

DIAGNOSIS/CONDITION: ____

REQUESTED PROCEDURE(S): Please Check

☐ **Evaluate and Treat**
☐ Epidural Steroid Injections: Cervical Thoracic Lumbar Caudal
☐ Cervical Facet/Nerve Block Level __________ Side __________
☐ Lumbar Facet/Nerve Block Level __________ Side __________
☐ Radio frequency Ablation Lumbar / Cervical Facet Nerves Level __________ Side __________
☐ Selective Nerve Root Block Level __________ Side __________
☐ SI Joint Injection RT LT B/L
☐ Intercoastal Nerve Block Level __________ Side __________
☐ Lumbar Sympathetic Block RT LT B/L
☐ Stellar Ganglion Block RT LT B/L
☐ Discography Levels ______________________
☐ Vertebroplasty / Kyphoplasty Levels ______________________
☐ Spinal Cord Stimulation, trial
☐ Trigger Point Injections Site ______________________
☐ **Other:** ______________________

Referring Physician Information:

Practice name: ______________________ Contact Person: ______________________

Phone: ______________________ Fax: ______________________

Physician Signature: ______________________ **Date:** ______________________

Questions? Please contact our Referral Coordinator at (770) 410-4534

THANK YOU FOR YOUR REFERRAL!

PAIN & SPINE CENTER
PHYSICIAN REFERRAL FORM
PC509

Patient Label Here