



**Pain & Spine Center  
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**