



**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

Intercostal Nerve Block Level _____ Side _____

Lumbar Sympathetic Block RT LT B/L

Stellate 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: _____ Time: _____

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

THANK YOU FOR YOUR REFERRAL!

**PAIN & SPINE CENTER
PHYSICIAN REFERRAL FORM**

PC509

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Patient Label Here