Kenai Spine

PHYSICIAN REFERRAL FORM
FOR PHYSICIANS ONLY

1 Patient information

Last Name ____________________ First Name ____________________ MI ______

Date of Birth (M/D/Y) ____________________ Personal Phone # ____________________ Work Phone # ____________________

Diagnosis/Symptoms ____

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2 Referred for

Referring doctor: ____________________

Physical Medicine/Pain Medicine: ☐ Eval/Treat ☐ 2nd opinion only

Spine Surgeon: ☐ Eval/Treat ☐ 2nd opinion only

Physical Therapy: ☐ As indicated ☐ PT only (I will manage other care)

☐ No PT (I will manage PT)

Electrodiagnostics (EMG/NCV): ☐ As indicated by Diagnosis/Symptoms

☐ Specific request ____________________

Report to me within: ☐ 5 - 7 days

☐ Urgent - 1 - 2 days

☐ Same day - please call

Diagnostic/Therapeutic Injections ☐ within 2 - 5 days ☐ 1 day - please call

☐ Epidural: ☐ Caudal/Lumbar ☐ Transforaminal Level(s)/Side(s) ____________

☐ Facet Joint(s) Level(s)/Side(s) ____________________

☐ Medial Branch Block(s) Level(s)/Side(s) ____________________

☐ Selective Nerve Root Block Level(s)/Side(s) ____________________

☐ Sacroiliac, Intra-Articular ☐ Right ☐ Left

☐ Hip, Intra-Articular ☐ Right ☐ Left

☐ Trigger Point(s) Location(s) ____________________

☐ Other injections ____________________

☐ Provocative Lumbar Discography: Suspected Level(s) ____________________

☐ With post-procedural CT

3 Authorization

Signature ____ Today's Date ____________________

Contact Telephone # ____

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