

SPINAL DIAGNOSTICS

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NEW PATIENT REFERRAL FORM

Name _____ Date of Birth _____ Patient Phone _____

Diagnosis _____

Referring Practitioner _____

Patient to See: *(leave blank for 1st available)*

- Dr. Heros
- Dr. Anderson

- Tyler Huntington,
PA-C

Service Requested:

- Comprehensive Spine Evaluation / Office Consultation
- Evaluate for Spinal Cord Stimulation/DRG Trial
- Evaluate for Pelvic Pain *(Dr. Heros only)*
- Evaluate and treat PTSD *(Dr. Anderson only, to consider stellate ganglion block)*
- Request for Intervention under Monitored Anesthesia Care:

Level(s) _____

- Epidural Steroid Injection
- Facet Joint Injection
- Diagnostic Facet Block / RFA
- Sacroiliac Joint Inject
- Other _____
- Diagnostic Only
- Therapeutic Injection

REFERRING OFFICE: PLEASE INCLUDE PATIENT DEMOGRAPHICS, INSURANCE INFORMATION, RECENT CHART NOTES, ANY SPINAL IMAGING REPORTS AND INSURANCE AUTHORIZATION # IF REQUIRED

Signature _____

Date _____