

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
- ☐ Ayumi Mizuno,
AGNP-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

- ☐ Diagnostic Only
- ☐ Therapeutic Injection

☐ Other _____

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

Signature _____

Date _____