COASTAL SPINE
& SPORTS MEDICINE PLLC

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REFERRAL FORM

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PATIENT

Name: _____ DOB: _____ Date : _____

Address: _____ Cell #: _____

_____ Home #: _____

Insurance: _____ Auth #: _____

REFERRING OFFICE/PROVIDER

Provider Name: _____

Phone #: _____ Fax #: _____

REASON FOR REFERRAL

- ☐ Physician/Provider Discretion
- ☐ Evaluation and Comprehensive Treatment
  - ☐ Including injections and medication management as indicated
- ☐ Evaluation and Injection (follow up with referring provider)
- ☐ Injection Only (follow up with referring provider)
- ☐ Transfer of Care

Include Clinic Notes / Xray / CT / MRI Reports

PRESCRIBED INJECTION PROCEDURE

- ☐ Therapeutic
- ☐ Diagnostic

REGION

- ☐ Cervical
- ☐ Thoracic
- ☐ Lumbar
- ☐ Joint
- ☐ Tendon
- ☐ Bursa

LOCATION/SITE

- ☐ Right Side
- ☐ Left Side
- ☐ Bilateral

PROCEDURES

- ☐ Selective Nerve Root Block
- ☐ Transforaminal Epidural Steroid Injection
- ☐ Interlaminar Epidural Steroid Injection
- ☐ Facet Joint Blocks
- ☐ Medial Branch Blocks
- ☐ Radiofrequency Ablation
- ☐ Peripheral Joint Blocks Specify: _____
- ☐ Peripheral Nerve Blocks Specify: _____
- ☐ Dorsal Root Ganglion Block
- ☐ Stellate Ganglion Block
- ☐ Lumbar Sympathetic Block
- ☐ Ganglion of Impar Block
- ☐ Sphenopalatine Ganglion Block
- ☐ Discography
- ☐ Spinal Cord Stimulator / Dorsal Column Stimulator
- ☐ Botox (Spasmodic Torticollis, Cervical Dystonia, Spasticity)

With this form, please fax
Insurance Cards / Medical Records / Imaging Studies