JOHNSON REGIONAL MEDICAL CENTER

REFERRAL FORM

AUTHROIZATION FOR RELEASE OF INFORMATION

REFERRING PROVIDER INFORMATION	
PROVIDER NAME: (MD/DO/DPM/NP/PA/DPT)	
CLINIC NAME:	
ADRESS (CITY, STATE, ZIP):	
PHONE #:	FAX #:
SIGNATURE:	DATE:

PATIENT INFORMATION	
PATIENT NAME: (*Last, First, Middle)*	
Date of Birth: (MM/DD/YYYY)	
HOME PHONE:	WORK PHONE:
	CELL PHONE:
INSURANCE (*PRIMARY*):	
POLICY #:	GROUP #:
INSURANCE (*SECONDARY*):	
POLICY #:	GROUP #:

❑ **Please release my records from the referring provider above to Johnson Regional Medical Center.**

_____ _____

Patient Signature Today's Date

TREATMENT REQUEST		
❑ Evaluation and Treatment of Pain Condition described below:		
❑ Intervention Request / Procedure only list below:		
DIAGNOSTIC	**THERAPEUTIC**	**SYMPATHETIC**
❑ Medial branch/facet blocks	❑ Epidural Steroid Injection	❑ Sphenopalatine
❑ Selective nerve root block	❑ Facet Steroid Injection	❑ Stellate
❑ Sacral lateral branches	❑ Joint or Soft Tissue Injection	❑ Lumbar
❑ Lumbar puncture	❑ RF Ablation	❑ Ganglion

PAIN DESCRIPTION					
Diagnosis, Impression or Description:					
❑ Back Pain		❑ Malignant Pain		❑ Post Laminectomy Pain	
❑ Neck Pain		❑ Radiculopathy		❑ Complex Regional Pain Syndrome	
Duration of Pain	❑ < 1 month	❑ 1-3 months	❑ 3-12 months	❑ 1-3 years	❑ >3 years

**** Please fax/email relevant clinical notes and images with this form.**