APS | Atlanta Pain & Spine *Physicians*

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Date of Referral _____

Referring Physician Name _____

Referring Physician Phone Number _____

Patient Information

Name _____ Date of Birth _____

Phone (Home) _____ (Work) _____ (Cell) _____

Brief History

Diagnosis _____

Symptoms _____

Reason For Referral

_____ Evaluation Only (*Recommendations for management only*)

_____ Evaluation and Treatment

_____ Procedure: (*Please circle and/or specify if able*) _____

Epidural Steroid Injection
Transforaminal Epidural Steroid injection
Selective Nerve Root Block
Facet Injection
Medial Branch Block
Radiofrequency Ablation
Sacroiliac Joint Injection
Lumbar Discography
Stellate Ganglion Block
Lumbar Sympathetic Block
Occipital Nerve Block
Joint Injection
Trigger Point Injection
Spinal Cord Stimulator Trial
Other

Please fax the following information, if available:
A copy of the patient's insurance card and demographics
A copy of any diagnostic imaging reports (CT/MRI) specific to the pain problem
A copy of the H&P and most recent clinical note

Please fax referral and additional information to (770) 790-4811
Thank you for allowing Atlanta Pain and Spine Physicians to participate in your patient's care!