PATIENT REFERRAL FORM

Phone: 757-227-3820 Fax: 757-226-9021

www.COVAspineandpain.com

Patient's Name: ☐ Male ☐ Female D.O.B.

Home Phone: Work Phone : Ext: Cell Phone:

Insurance: Policy Number: HMO Referral #

Diagnosis: ICD 9: ICD 10:

Referring Physician: Contact Person: Office #: Fax #:

Preferred Physician: ☐ First Available ☐ **SPEAR** ☐ **NOCK**

Preferred Physical Therapist: ☐ First Available ☐ **Bragg** ☐ **Burch** ☐ **Levine**

CONSULTATION, TESTING, TREATMENT

☐ **Physiatric Consultation** ☐ EMG/Nerve Conduction Study: Area: _____

☐ Diagnostic Ultrasound (Musculoskeletal): Area: _____ ☐ Headache Consultation

☐ Physical Therapy Evaluation/Treatment *(Please attach script)* Area:

Comments:

PROCEDURES *(HUMANA insurance requires prior consultation.*

☐ Epidural Steroid Injection: Area:

☐ Facet Joint Injection: Area:

☐ Sacroiliac Injection

☐ RadioFrequency Denervation (Requires Previous Diagnostic Blocks): Area:

☐ Image Guided Injections: ☐ Fluoroscopic ☐ Musculoskeletal Ultrasound Area:

☐ Spinal Cord Stimulator Trial: Area:

☐ Botox Injection (Consultation Required): Area:

☐ Regenerative Medicine: ***(Requires Consultation)*** ☐ Prolotherapy: Area:

☐ Platelet Rich Plasma (PRP): Area:

☐ ***Other:***

PLEASE ATTACH THE FOLLOWING INFORMATION:

- Referral, if required
- Copy of insurance card/WC claim information
- Patient Demographics
- Recent Office Notes

***** We DO NOT participate in the following insurances*****

- **North Carolina Medicaid**
- **All Medicaid HMO's**
- **BCBS – Dual**
- **MAMSI**

For CoVA Office Use Only:

Dr. _____ ***Appointment Date:*** _____ ***Appointment time:***_____

☐ *Attempted to contact patient - NO RESPONSE* ☐ *Not scheduled after medical review*

Comments: