

# REFERRAL FORM



## iSpine Pain Physicians

- |                                    |                                      |                                   |
|------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Chaska    | <input type="checkbox"/> Coon Rapids | <input type="checkbox"/> Delano   |
| <input type="checkbox"/> Edina     | <input type="checkbox"/> Maple Grove | <input type="checkbox"/> Shakopee |
| <input type="checkbox"/> St. Cloud |                                      |                                   |

**Schedule by calling or faxing:**

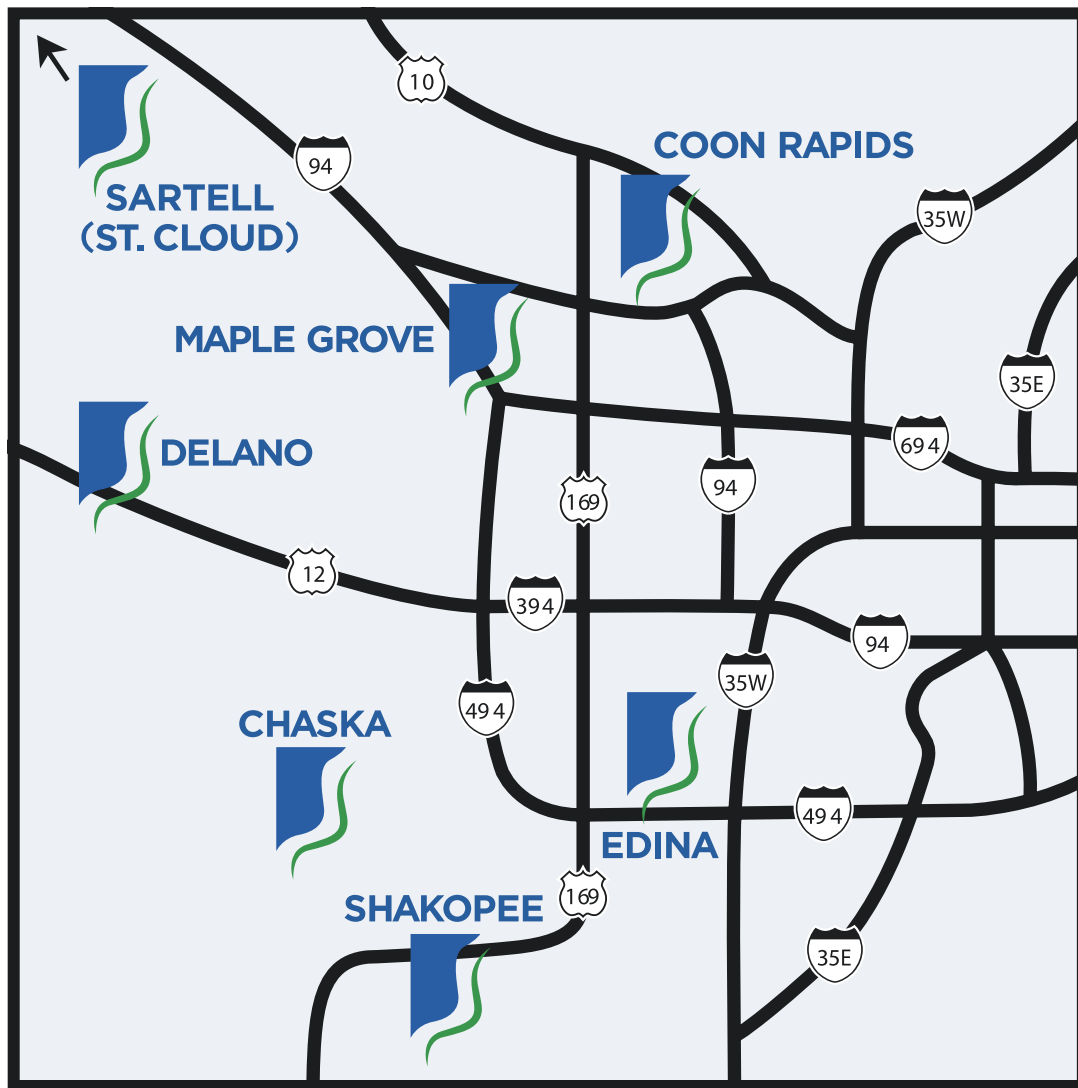
Phone: 763-201-8191 | Fax: 952-303-4027

Patient Name (as shown on insurance card)			Primary Phone		
Patient DOB	<input type="radio"/> Male <input type="radio"/> Female	Authorization#		Authorization Insurance Phone	
Insurance		Insurance ID #		Group #	
<input type="checkbox"/> Auto <input type="checkbox"/> Workers' Comp <input type="checkbox"/> Commercial/Private		Date of Injury		Attorney Name/Claim #	
<b>(REQUIRED) Written diagnosis/reason/symptom for exam(s).</b> Must include <b>specific</b> indications (such as location, context and severity) to support medical necessity for each test.					
Area of Body		Level _____	<input type="radio"/> Cervical <input type="radio"/> Thoracic <input type="radio"/> Lumbar	<input type="radio"/> R <input type="radio"/> L <input type="radio"/> B	

**Please fax the most recent notes, imaging reports, PT/OT notes and demographics with referral.**

- |   |   |
|---|---|
| <input type="checkbox"/> Epidural Steroid Injection   | <input type="checkbox"/> Provocative Discography            |
| <input type="checkbox"/> Selective Nerve Root Block   | <input type="checkbox"/> Vertebroplasty/Kyphoplasty         |
| <input type="checkbox"/> SI Joint Injection   | <input type="checkbox"/> Trigger Point Injection            |
| <input type="checkbox"/> Piriformis Muscle Injection  | <input type="checkbox"/> Spinal Cord Stimulation Evaluation |
| <input type="checkbox"/> Facet Joint Injection  | <input type="checkbox"/> Intra-Articular Joint Injection    |
| <input type="checkbox"/> Diagnostic Medical Branch Block/Rhizotomy Eval   |   |
| <input type="checkbox"/> Peripheral Nerve Block: <input type="radio"/> Ilioguinal/Genitofemoral <input type="radio"/> Ulnar <input type="radio"/> Occipital |   |
| <input type="checkbox"/> Bursa Injection: <input type="radio"/> Greater Trochanter <input type="radio"/> Subdeltoid <input type="radio"/> Ischial           |   |
| <input type="checkbox"/> Sympathetic Block: <input type="radio"/> Stellate Ganglion <input type="radio"/> Lumbar Sympathetic                                |   |
| <input type="checkbox"/> Consultation/Evaluate & Treat _____  |   |
| <input type="checkbox"/> Other _____  |   |

Provider Name (print)		Phone
Clinic Name		Location (City)
Provider Signature (required)	NPI# (required)	Date



## OUR CLINIC LOCATIONS

### Chaska

Ridgeview Chaska Medical  
3000 Hundertmark Rd.  
Suite 200\* & Suite 250

### Coon Rapids

Mercy Specialty Center  
11850 Blackfoot St. NW  
Suite 490

### Delano

Ridgeview Delano Clinic  
916 Saint Peter Ave.

\* Ambulatory Surgery Centers

### Edina

7700 France Ave. S  
Suite 260

### Maple Grove

9645 Grove Circle North  
Suite 200 & Suite 250\*

### Shakopee

St. Francis Medical Center  
1601 St. Francis Ave.

### Sartell

St. Cloud Orthopedics  
1901 Connecticut Ave. S



## HOURS

Monday - Friday ..... 8:00 am - 5:00 pm  
Saturday & Sunday ..... Closed

[www.ispinepainphysicians.com](http://www.ispinepainphysicians.com)