Center for Spine Interventions

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REFERRAL / CONSULTATION REQUEST

Please fax referral to 770.575.3912

Patient Name: ______________________________ DOB: __________

Address: ______________________________

Patient Phone: ______________ Diagnosis: ______________

Patient Insurance: ______________ Policy Number: ______________

EVALUATE AND TREAT

Epidural Steroid Injection:	Cervical	Thoracic	Lumbar
Facet Joint / Facet Nerve Block:	Cervical	Thoracic	Lumbar
Radiofrequency Ablation:	Cervical	Thoracic	Lumbar
SI Joint Injection:	Right	Left	
Knee Genicular Nerve Block/Ablation:	Right	Left	
Vertiflex Superion:			
Regenerative Medicine (PRP, Stem Cell):			
Kyphoplasty:	Lumbar: __________	Thoracic: __________	
Provocative Lumbar Discogram:	Levels: __________		
Spinal Cord Stimulator	Trial	Permanent	

Referring Physician Name: ______________________________ Date: __________

2713 Charles Hardy Parkway • Suite 222/224 • Dallas, GA 30157

4586 Timber Ridge Drive • Suite 140/141 • Douglasville, GA 30135

4450 Calibre Crossing • Suite 1118/1120 • Acworth, GA 30101

980 Woodstock Parkway • Suite 300 • Woodstock, GA 30188

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