677 South Main Street • Cheshire, CT 06410
100 Broadway • North Haven, CT 06473
Phone: (203) 439-0050 • Fax: (203) 439-9490

REFERRAL/PROCEDURE REQUEST

Patient's Name:______________________________ SS#:____________________

Address:____

City:__________________________________ State:________ Zip:____________

Phone: ______________________________ Date of Birth:____________________

Insurance: ____________________ ID#: ________________ Group:____________

Workers Comp: _________________ PH#: ________________ Auth#:____________

Case Manager:____

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Evaluation and treatment: ____Yes _____No Symptom:____________________________

Anticoagulants: ____ None ____ Coumadin ____ Plavix ____ Ticlid ____ Lovenox ____ Aggrenox

REQUESTED PROCEDURE:

____ Lumbar Epidural Steroid Injection ____ Cervical Epidural Steroid Injection

____ Selective Nerve Root Block/Level ____ Median Branch Block/Facet/Level

____ Trigger Point Injection ____ Other

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Physician's Name:____

Physician's Telephone Number:______________________ Fax: ___________________

Contact Person:_______________________ Phone#: _________________________

PLEASE FAX ANY MRI REPORTS WITH LAST THREE MONTHS OF NOTES

PLEASE FAX REQUESTS TO 203-439-9490