ADVANCED PAIN MANAGEMENT & REHAB MEDICAL GROUP, INC.
Ravi Panjabi, MD
Riddhi Patel, PA-C Joann Dumas, FNP
19850 Lake Chabot Rd, Castro Valley, CA 94546 510-582-8555 Fax: 510-581-8686
1081 Market Pl #100, San Ramon, CA 94583 925-242-0810 Fax: 510-581-8686
2324 Santa Rita Rd #9, Pleasanton, CA 94566 925-846-1701 Fax: 510-581-8686

REFERRAL FORM

Please call or fax this completed from along with insurance authorization if required our office will contact the patient as soon possible. Please send/fax relevant medical records including MRI scan reports, EMG reports, etc.

Patient Name: _____ Date: _____

Address: _____

Home Phone: _____ Work Phone: _____

Referring Office: _____

Address: _____

Phone: _____ Fax: _____

☐ Evaluation and Treatment (Comprehensive Consultation and/or follow-up care, including injections and medications if necessary)

☐ Evaluation and Injection (Comprehensive consult with therapeutic injection(s))

☐ Injection Only

☐ Transfer Primary Treating Physician Status (PTP)

Prescribed Injection	**Indicate Level**	**Series of**
☐ Epidural Steroid Injection	☐ Lumbar	☐ Left ☐ One
☐ Selective Nerve Root Block	☐ Cervical	☐ Right ☐ Two
☐ Discography	☐ Thoracic	☐ Bilateral ☐ Three
☐ Post Discogram CT scan (please obtain authorization)		
☐ Sacroiliac Joint Injection	☐ Level: _____	
☐ Stellate Ganglion Block	☐ Diagnostic	
☐ Lumbar Sympathetic Block	☐ Therapeutic	
☐ Lumbar Sympathetic Block		
☐ Radiofrequency Rhizotomy		
☐ Implantable Therapy		
☐ Spinal Column Stimulator ☐ Morphine Pump Implantation		
☐ Disc Decompression		
☐ Vertebroplasty		
☐ Other: _____		

INSURANCE INFORMATION: ☐ Industrial ☐ Private ☐ Medicare ☐ HMO ☐ Other _____

Insurance Carrier: _____

Claim/ID #: _____ DOI/Group #: _____

Adjuster/Medical Group: _____

Phone: ( )_____ Fax: ( )_____

Address: _____

Authorization/Verbal per _____ No pre-cert needed per _____

Date: _____ Employer: _____

For Office Use Only

Date Appointment Scheduled: _____

Location Scheduled: _____