Justin Porter, M.D.
Garrett K. Wright, M.D.
Elwood "Trey" Williams, M.D.

FAX REFERRAL FORM

Procedure Instructions

- **Please notify our office if patient is on blood thinners.**
- **Patient must have a driver to accompany and remain with them.**

To facilitate the referral process, please fax this **completed form, patient demographics, insurance information, MRI report** and **other pertinent medical records** to the number below. We will make initial contact with the patient within 24 hours after receiving the information.

DATE: _____

TO: **OPM**
FAX: **405-775-9356** PHONE: 405-242-4100 ATTENTION: Scheduler

FROM:
Referring Physician:_____
Phone: _____ Fax:_____ Contact Person:_____

North Office:
3601 N.W. 138th Street, Suite 200
Oklahoma City, OK 73134

South Office:
Brookwood Medical Center
937 S.W. 89th Street, Suite C
Oklahoma City, OK 73139

PATIENT:
Name:_____ Diagnosis_____
Phone: Home_____ Cell_____ Work_____
Date of Birth:_____SS#_____

Requested Procedures and/or Treatment

_____Evaluate and Treat

_____Epidural Steroid injections _____Lumbar _____Cervical
_____Discogram _____Lumbar _____Cervical
_____Selective Nerve Root Block
_____Evaluation for Spinal cord stimulator
_____Consultation with recommendations
_____Other_____

Follow Up with:
_____Pain Management Physician
_____Referring Physician

Thank You!