



FAX REFERRAL FORM

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To streamline the referral process, please fax the completed form along with patient demographics, insurance details, MRI reports, and any relevant medical records to the number below. Our team will contact the patient within 24 hours of receiving the referral.

To : _____ **OPM** _____ **ATTN** : _____ **Scheduler** _____
Date : _____
Fax Number : _____ **405-775-9356** _____ **Phone Number** : _____ **405-242-4100** _____
From : _____ **Contact Person** : _____
(Referring Physician)
Fax Number : _____ **Phone Number** : _____

PATIENT INFORMATION

Full Name : _____
(please use capital)
Date Of Birth : _____ / _____ / _____ **Gender** : Male Female
Phone Number : _____ **SSN** : _____
Email : _____
Diagnosis : _____

REQUESTED PROCEDURES/TREATMENTS

Evaluate and Treat : **Consultation with recommendations** :
Selective Nerve Root Block : **Evaluation for Spinal Cord Stimulator** :
Epidural Steroid Injections : **Lumbar** : **Cervical** :
Discogram : **Lumbar** : **Cervical** :
Other : _____

Follow up with

Referring Physician : **Pain Management Physician** :

THANK YOU

North Office

3601 NW 138th St, Ste 200
Oklahoma City, OK 73134

Shawnee Office

4409 N Kickapoo, Ste 129
Shawnee, OK 74804

Norman Office

4023 N Flood St
Norman, OK 73069

Yukon Office

1703 Professional Cir, Ste 101
Yukon, OK 73099