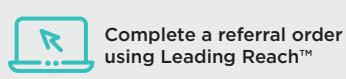
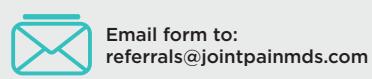
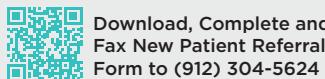


## JOINT PAIN TREATMENT REFERRAL FORM

Today's Date:	Patient DOB:		
Patient Name:	<input type="checkbox"/> M <input type="checkbox"/> F		
Primary Care Physician:	Phone:		
<b>PATIENT DEMOGRAPHICS</b> (may attach face sheet instead)			
Address:	City:	State:	Zip:
Phone:	Alternate Phone:		
<b>PATIENT INSURANCE INFORMATION</b> (may attach face sheet instead)			
Primary:	ID#:	Group#:	
Phone:			
Secondary:	ID#:	Group#:	
Phone:			
REFERRAL REASON	Wound Location	Wound Size	
<input type="checkbox"/> Knee pain	<input type="checkbox"/> Frozen shoulder	<input type="checkbox"/> Rotator Cuff injury	
<input type="checkbox"/> Hip pain	<input type="checkbox"/> Back pain	<input type="checkbox"/> Elbow pain	
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Tendonitis	<input type="checkbox"/> Degenerative Disk Disease	
<input type="checkbox"/> Sciatic pain	<input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Plantar Fascitis	
<input type="checkbox"/> Other			
<b>ADDITIONAL COMMENTS:</b>			
Does Patient have a cardiac pacemaker/defibrillator?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Does Patient have an infusion pump?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
Does Patient have a bleeding disorder?	<input type="checkbox"/> No <input type="checkbox"/> Yes		
<b>REFERRER INFORMATION</b>			
Name:	Phone:	Fax:	
Referral Source:	<input type="checkbox"/> Physician <input type="checkbox"/> Home Health	<input type="checkbox"/> Discharge Planner <input type="checkbox"/> Other:	<input type="checkbox"/> Nursing Home

**We will contact patients within 24 hours to schedule their appointment.  
Thank you for your continued support and trusting us with your patients.**



**PLEASE INCLUDE ALL RELEVANT MEDICAL RECORD PROGRESS NOTES WITH DIAGNOSIS, LAB TESTS AND IMAGING RESULTS.**

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