Spine Center of Excellence Referral Form
(Optional Tool)

Today's Date: _____ Date of Onset: _____

Patient Name: _____ Date of Birth: _____

Home Phone: _____ Work Phone: _____

Provisional Diagnosis: _____

Current Medications: _____

Insurance: _____

REQUEST FOR:

- ☐ Evaluation & Recommendations by a physical medicine and rehabilitation provider (physiatrist)
- ☐ Evaluation & Treatment by physiatrist

The PCP will provide the following completed diagnostic tests: (please circle all that apply & fax documentation)

X-ray CT MRI Bone Scan EMG Other _____

Please fax the following additional information if available:

- ☐ Current medical history
- ☐ Past medical history
- ☐ Any other consultant's evaluation/treatment/interventions
- ☐ Prior therapy/specialist consultation (e.g. neurosurgery, orthopedic, pain clinic) provide names of prior consultants: _____

If the Spine COE recommends surgical or physical therapy referral and there is a provider preference please indicate:

1. Surgical referral: _____
2. Physical therapy referral: _____

_____

Physician's Signature Date

_____

Physician's Name (PRINTED) Phone

_____

Office Contact Person

RECOMMENDATION: (to be completed by the Physiatrist)

- ☐ Preliminary clinical impression: _____
- ☐ Physiatry consult
- ☐ Interventional pain management
- ☐ Physical therapy
- ☐ Neuro or orthopedic surgery
- ☐ Work hardening
- ☐ Diagnostic tests _____

This form is for voluntary use by the PCP and Physiatrist. Do not send to Priority Health. A complete list of Spine COEs and their fax numbers is available at *priorityhealth.com/provider/clinical/backpain.*