Patient Referral/ Consultation Form

Michael Najjar, MD
Board Certified Pain Management
Board Certified Anesthesiology

Date:_______________

Referring Physician:_______________________________

Referring Physician Phone Number:___________________

Patient Name:____

DOB:_____________ SSN:________________________

Address:____

Phone Number:____________ Insurance Type:_____________________________

Reason for referral/symptoms:

____

Is this patient covered by worker's compensation? ______________________

Case Manager:__________________ Phone Number:____________________

Date of Injury:__________________ Claim Number:______________________________

Has this patient been seen in another Pain Clinic?____________

Why is the patient leaving the Pain Clinic?____

Please Circle One:

Evaluation and Procedure OR Evaluation and Treatment

If procedure, please indicate Level and Side Requested:__________________________________

Is this patient currently taking Blood Thinners? **Yes or No if yes, Plavix or Coumadin** (please circle one)

Lumbar Epidural _____ Foraminal Epidural _____ Selective Nerve Root Block _____

Thoracic Epidural _____ Facet Joint Injection _____ Radiofrequency _____

Cervical Epidural _____ Stellate Ganglion Block _____ Sacro-Iliac Injection _____

Epidural Blood Patch _____ Lumbar Sympathetic Block _____ Discogram _____

STAT (urgent 1-2 days)_____ ASAP (2-3 days) _____ Routine (1-2 weeks) _____

Please fax all medical records, diagnostic reports and insurance cards to: (877) 752-3416

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