Physical Medicine Associates

Referral Form

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| Date: | |
| Patient Name: | DOB: |

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| Referring Diagnosis: |
| Referring To (if left blank/no preference we will delegate to the most appropriate and next available provider):  Dr. Jonathan Pedrick  Dr. Robert Perkins Dr. Jeffrey Strakowski Dr. Emily Yu |
| Status:  Routine  Urgent |
| Referral Request:  Consult (codes 99213-99215)  EMG+NCS (codes 95886, 95907-95912) area: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Ultrasound (codes 99213-99215, 76881) area: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  US guided injection (codes 76942) area/addtl. comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Additional Provider Comments: |
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**To aide in expediting the referral process, please Include:**  
- Patient Demographics including insurance information  
- Office visit notes

- Pertinent/associated diagnostic images and reports  
- Specific coding on authorizations (codes our office uses listed above)