Spinal Decompression Clinics of Minnesota, LLC

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Patient Referral Form

The primary treating physician indicated on this form is referring his/her patient for a second opinion/ evaluation and/or treatment.
This Patient is NOT changing his/her Primary Treating Physician.

Today's Date:_____ Date of Injury (if any): _____ ❒Auto Accident ❒Work Injury ❒Other

Patient Name:_____ Sex: ❒M ❒F Marital Status: ❒M ❒S ❒D ❒W

Address:_____

City:_____ State:_____ Zip Code: _____

Social Security Number: _____ Date of Birth: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

Referring Primary Physician:

Name & Title: _____ Clinic/Practice Name:_____

Address:_____

City:_____ State:_____ Zip Code: _____

Email Address: _____

Phone: ( ) _____ FAX: ( ) _____ Signature:_____

Reason for Referral: (Check all that apply)

- ❒ Persistent, moderate to severe, non-resolving low back or neck pain.
- ❒ Persistent, moderate to severe, non-resolving referring leg or arm pain.
- ❒ Patient has a recent (within 16 months) **MRI / CT Scan** (circle). Is it available for review? ❒Yes ❒No
- ❒ Please evaluate for possible Cervical or Lumbar Disc Decompression Therapy (DRX9000) at Spinal Decompression Clinics of Minnesota.
- ❒ Attempt to prevent surgical intervention.
- ❒ Determine if patient needs a surgical consultation.
- ❒ Patient desires a DRX9000 or DRX9000C consultation only.
- ❒ Second opinion only.

Current Diagnostic Impressions and Discussion:

ICD Code(s) and Explanation: _____|_____|_____

_____

Insurance Information (type): ❒Auto ❒Workers Comp

Insurance company: _____ Claim/Policy Number: _____

Address:_____

City:_____ State:_____ Zip Code: _____

Claims Adjuster: _____ Phone: ( ) _____ FAX: ( ) _____

Have you discussed Spinal Decompression with this Claims Adjuster? ❒Yes ❒No

Please FAX completed form to: Andover Clinic (763) 421-1044 or Lake Elmo Clinic (651) 777-2426