NEW PATIENT REFERRAL FORM

JACKIE T. CHAN, M.D., INC.

PAIN MANAGEMENT
PHYSICAL MEDICINE & REHABILITATION
ELECTRODIAGNOSIS

809 Sylvan Avenue, Suite 400
Modesto, CA 95350
(209) 529-4422 Fax (209) 529-1711

DATE: _____/_____/_____

Patient's Name:		**DOB**	
SS#		**DOI**	
Address:		**P&S**	□ Yes □ No
		Telephone:	

Insurance:		Claims Adjuster	
Address:		Tel: Fax:	

➡ **Authorization Status:** □ **Authorized** □ **Authorization Pending**

Referring Physician:			
Address:		Tel: Fax:	

Attorney:			
Address:		Tel: Fax:	

CONSULTATION OPTIONS (Please check one of the following)

□ Electrodiagnosis (EMG/NCS) – (specify limbs): _____

□ Evaluate and treat as primary treating physician □ Consult and intervention (limited to those checked below)

□ Evaluate and treat as secondary treating physician □ Second opinion (one time consult only)

DIAGNOSTICS AND INTERVENTIONS

□ EMG/NCS (specify limb(s)): _____ R/O: _____

□ Acupuncture: For Dx:_____

□ Epidural (specify location): _____

□ Facet Injection (specify location): _____

□ Joint Injection (specify location): _____

□ Medial Branch Block (specify location): _____

□ Trigger Point Injection (specify location): _____

□ Other (specify): _____

_____ _____

Physician Name (please print) *Physician Signature*

PLEASE FAX THIS FORM TO: (209) 529-1711