



GREGORY GULLO, MD
SUSAN RING, PA-C

Phone (503) 512-1212
 Fax (503) 512-1220

REFERRAL REQUEST FORM

Today's date:			Referring Physician:		
PATIENT INFORMATION					
Patient Name: Last		First	Middle	Date of Birth:	PCP:
Address:			Social Security #:		Home phone:
City:		State:	Zip:	Other Phone:	

Is the pain related to a work injury? Yes No **If yes, Date of Injury:** _____

Accepted Dx: _____

Is the pain related to a MVA: Yes No **If yes, Date of Injury:** _____

INSURANCE COVERAGE (OR ATTACH COPY OF INSURANCE CARDS)						
Primary Insurance:			Phone:			
Billing Address, City, State, Zip:			ID #:	Group #:		
Subscriber Name: Last		First	Middle	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	Relationship to Patient:
Secondary Insurance:			Phone:			
Billing Address, City, State, Zip:			ID #:	Group #:		
Subscriber Name: Last		First	Middle	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:	Relationship to Patient:

Pain Management/Consultation Request: Consultation Only Consultation + Treatment Procedure Only

Procedure Type: Epidural/Selective Nerve Root Block Facet Joint/Nerve Injection Discography RFA
 Diagnostic Injection Therapeutic Injection

Level(s): _____ **Diagnosis:** _____

Post Discogram CT to follow: Yes No **If yes, indicate views:** Full CT View Disc Only

Please include the following items with completed faxed request form:

- Copy of Insurance Card (Front & Back)
- Work Comp or MVA Billing Information (if applicable)
- Recent Chart Notes
- Recent Diagnostic Imaging