ADVANCED
Spine & Orthopedics

OBINNA C. EMECHEBE, MD
Interventional Pain Physician
Board Certified, Fellowship Trained

PLEASE FAX THIS REFERRAL FORM TO: **(817) 431-0735**

2813 W. Southlake Blvd, Suite 100 Southlake, TX 76092

◆**www.ASODocs.com** ◆**Phone: (817) 310-8783** ◆**referrals@asodocs.com**

Date: _____

Referring Clinician: _____ Patient Name: _____

Referring Clinician Phone: _____ Patient DOB: _____

Referring Clinician Fax: _____ Patient Phone: _____

Referring NPI: _____ Patient Email: _____

☐ Evaluate and Treat as deemed appropriate ☐ Procedure Only Consult

☐ Special Request: _____

PLEASE SUBMIT THE FOLLOWING DOCUMENTATION WITH YOUR REFERRAL

☒ MEDICAL RECORDS ☒ AVAILABLE IMAGING ☒ PATIENT DEMOGRAPHIC SHEET

☒ COPY OF INSURANCE CARD ☒ WORKERS' COMP INFORMATION (INCLUDING DATE OF INJURY)

FOCUSED PAIN PROBLEM/COMPLAINT (SELECT ALL THAT APPLY)

☐ HEADACHE ☐ NECK PAIN ☐ MID/LOW BACK PAIN ☐ SHOULDER PAIN ☐ HIP PAIN ☐ KNEE PAIN
☐ OTHER JOINT PAIN ☐ POST SURGICAL CHRONIC PAIN ☐ CANCER PAIN ☐ SYMPATHETIC MEDIATED PAIN
☐ NEUROPATHIC PAIN ☐ MYOFASCIAL PAIN ☐ PHANTOM PAIN ☐ FIBROMYALGIA ☐ CHRONIC PANCREATITIS
☐ PELVIC PAIN ☐ SHINGLES/POST HERPETIC NEURALGIA ☐ FACIAL PAIN ☐ PERIPHERAL NEUROPATHY
☐ OTHER: _____

REQUEST A PROCEDURE (SELECT ALL THAT APPLY)

☐ ADHESIOLYSIS ☐ BALLOON KYPHOPLASTY ☐ BOTOX INJECTION (HEADACHE MGMT) ☐ DISCOGRAPHY
☐ DORSAL ROOT GANGLION ☐ EPIDURAL STEROID INJECTION ☐ FACET INJECTION / MEDIAL BRANCH BLOCK
☐ GENICULAR NERVE BLOCK / RFA ☐ OPIOID MANAGEMENT ☐ OCCIPITAL NERVE BLOCK ☐ PELVIC INJECTIONS
☐ PERIPHERAL NERVE BLOCKS ☐ PRP/STEM CELL INJECTION ☐ RADIOFREQUENCY ABLATION (C / T / L / S)
☐ SACROILIAC JOINT INJECTION ☐ SELECTIVE NERVE ROOT BLOCK ☐ SPINAL CORD STIMULATOR
☐ SYMPATHETIC BLOCKS (STELLATE, SPLANCHNIC, CELIAC, LUMBAR SYMPATHETIC, SUPERIOR/INFERIOR HYPOGASTRIC, GANGLION OF IMPAR) ☐ TRIGGER POINT INJECTION ☐ VERTIFLEX PROCEDURE
☐ OTHER: _____

WE WILL RETURN YOUR PATIENT BACK TO YOU ONCE THEIR PROCEDURE IS COMPLETE

Referring Clinician Signature: _____ Date: _____

THANK YOU FOR THIS REFERRAL AND FOR ALLOWING US TO PARTICIPATE IN THE CARE OF YOUR PATIENT.