ALPENGLOW
-- PAIN & WELLNESS --

www.AlpenglowPain.com

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PATIENT REFERRAL

Patient name:_____Date:_____

DOB:_____ Home Phone:_____Work Phone:_____

Insurance: _____ID Number:_____

Referring Physician:_____Contact Telephone: _____

PLEASE FAX COPIES OF ANY OF THE BELOW WITH THIS FORM

***DIAGNOSTIC REPORTS (MRI, CT, X-RAY, ETC...)**

***MOST RECENT PHYSICIAN NOTES**

***PATIENT DEMOGRAPHICS TO INCLUDE INSURANCE INFORMATION**

- ☐ Pain Evaluation & Consultation
- ☐ Hypermobility / Ehlers-Danlos Syndrome (EDS)
- ☐ Neck / Mid / Low Back Pain
- ☐ Cervical / Lumbar Radiculopathy
- ☐ Cervical / Lumbar Spinal Stenosis
- ☐ Complex Regional Pain Syndrome (CRPS)
- ☐ Peripheral Neuropathy
- ☐ Osteopathic Manipulation
- ☐ Ketamine Infusion Therapy
- ☐ Myofascial Pain Syndrome / Muscle Spasm / Trigger Points
- ☐ Stellate Ganglion Block for Long Haul Covid / PTSD / CRPS
- ☐ Sacroiliac joint pain
- ☐ Hip / Shoulder / Knee Pain
- ☐ Platelet Rich Plasma (PRP)
- ☐ Pelvic / Abdominal Pain
- ☐ Cancer Pain Management
- ☐ Post Herpetic Neuralgia
- ☐ Fibromyalgia
- ☐ Migraine / Other Headaches
- ☐ Facial Pain
- ☐ Medical Massage Therapy

Other Relevant Information:

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