LEGACY
PAIN & SPINE SPECIALISTS

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PLEASE FAX REFFERAL TO 205-847-5563

REASON FOR REFFERAL:
- ☐ EPIDURAL
- ☐ KYPHOPLASTY
- ☐ SPINAL STIMULATOR
- ☐ OTHER PROCEDURE OR INJECTION
- ☐ MEDICATION OR OPIOID EVALUATION

DATE: _____

REFERRING PHYSICIAN: _____

STAFF CONTACT NAME: _____

FAX: _____ PHONE: _____

PATIENT NAME: _____ DOB: _____

DIAGNOSIS: _____

INSURANCE: _____ POLICY #: _____

CELL: _____ HOME: _____

MAILING ADDRESS: _____

Please include the following:
- ☐ Any insurance requirements
- ☐ Recent imaging
- ☐ Last office visit note

We will contact the patient to schedule a consultation with our physicians and fax back the appointment time and date. If you have not received a reply in 72 hours, please contact our office. Thank you for your referral!

APPOINTMENT SCHEDULED: _____