



CHERYL WHITE MD

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**www.brazospain.com**

**PATIENT REFERRAL FORM**

PATIENT NAME: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

Patient Contact Phone: \_\_\_\_\_ Work/Cell/Home

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Referral / Consultation (Please circle one)

Diagnosis: \_\_\_\_\_

Reason for Consultation / Referral: \_\_\_\_\_

- Procedure Only (may modify at discretion of BPM Physician)
- Procedure Only (perform procedure as requested)
- Follow Up Injection(s) at discretion of BPM Physician
- Consultation with procedure at discretion of BPM Physician

Indicate appropriate level and side:

Procedure	Cervical	Thoracic	Lumbar	Level/Joint/Nerve & Side(s)
Interlaminar Epidural Steroid injection	62310	62310	62311	
Caudal Epidural Steroid Injection	62311			
Transforaminal Epidural Steroid Injection	64479	64479	64483	
→ Additional nerve(s)	64480	64480	64484	
Selective Spinal Nerve Block	64479	64479	64483	
→ Additional nerve(s)	64480	64480	64484	
Facet Joint Injection	64470	64470	64475	
→ Additional joint(s)	64472	64472	64476	
Medial Branch Injection (Specific Joint)	64470	64470	64475	
→ Additional joint(s)	64472	64472	64476	
Sacroiliac Joint Injection	27096			
Provocation Discography	62291	62291	62290	
Radifrequency Neurotomy	64626	64626	64622	
Sympathetic Block	64510		64520	
Spinal Cord Stimulator Trial				
Hip Joint Injection	20610			

**Special Requests:**