

**Jerry Lewis, MD**

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## REFERRED BY

Dr. \_\_\_\_\_ Office Phone Number: \_\_\_\_\_

## PATIENT REFERRAL FORM

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

*Please include a COPY of the PATIENTS Insurance Card, Demographics, and Previous*

## REQUEST

- Evaluate Only (Consult Only)
- Evaluate and Treat
- Medication Management Only (Surgery is anticipated)  Procedure Only
- Medical Management (Surgery not indicated)

## REQUEST

- |  |   |
|--|---|
| <input type="checkbox"/> Pars Injection          | <input type="checkbox"/> ESI Series, Lumbar             |
| <input type="checkbox"/> S.I. Joint R L          | <input type="checkbox"/> ESI Series, Cervical           |
| <input type="checkbox"/> Selective Root Block(s) | <input type="checkbox"/> ESI Level X @ _____            |
| R - L Level: _____                               | <input type="checkbox"/> Discogram, Lumbar _____        |
| R - L Level: _____                               | <input type="checkbox"/> Discogram, Cervical / Thoracic |
| <input type="checkbox"/> Facet Injection         | _____   |
| R - L Level: _____                               | <input type="checkbox"/> Other _____                    |

**PRIORITY LEVEL:**     Routine                       ASAP                       Urgent

\*Please see back for our office locations.

Questions? Visit our "For Doctors & Staff" page at [www.LewisPain.com](http://www.LewisPain.com) for helpful information.