iSCOREINC.COM

Referral Form

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☐ 51 N. 5th Ave, #301
Arcadia, CA 91006

☐ 317 S. Brand Blvd.,Suite A-103
Glendale, CA 91204

Please complete the form, then fax/e-mail along with the last office note, EMG/NCS, MRI, and any other pertinent imaging studies. Our Office will contact the patient for an appointment.
You may also call our office directly. Office Hours: 9:00 am to 5:00 pm.

☐ **Maxim Moradian, MD, QME, DABPMR, CAQSM, DABPM, DABRM**

☐ **Revik Vartanian, DO, DABPMR** ☐ **James J Lieu, DO, DABPMR**

Patient Information:

Patient Name:_____ D.O.B. ___/___/_____

SS#_____ Phone#: _____

E-mail: _____

Address: _____ City: _____ Zip: _____

Patient Insurance: _____
(Please include copy of front & back of insurance, Driver's insurance)

Referring Diagnosis: _____

Testing (Past 6 Months): _____

☐ X-Ray ☐ MRI ☐ CT Scan ☐ EMG/NCS ☐ Ultrasound ☐ Other: _____
(Please include copy of testing reports if possible)

Referring Provider's Name:_____

Referring Provider Ph:_____ E-mail: _____ Fax#_____

Office Contact Person: _____ Sender's Name _____

Please Check Preferences:

☐ **Consult & Treat** ☐ **Consult & Return with Recommendations** ☐ **Electrodiagnostic Testing (EMG/NCS)**

☐ **Injection Series (Must complete the Following)** ☐ **Spinal Cord Stimulation Consult**

☐ **Lumbar** **Level(s)**_____ **Circle One: (Left • Right)**

☐ **Cervical** **Level(s)**_____ **Bilateral Circle One: (Left • Right)**

☐ **Thoracic** **Level(s)**_____ **Bilateral Circle One: (Left • Right)**

☐ **Nerve Block** **Level(s)**_____ **Bilateral Circle One: (Left • Right)**

☐ **Joint** **Specify:**_____ **Bilateral**

After injection, patient to follow up with: ☐ Referring Provider ☐ iSCORE