



NEUROLOGICAL SURGERY

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PAIN MANAGEMENT REFERRAL

Please complete all fields.

Date: _____

Referring Provider's Name: _____ Referring Provider's Phone: _____

Referring Provider's Address: _____

Office Contact Name: _____ Office Contact Fax: _____

Patient's Name: _____ Date of Birth: _____

Home Phone #: _____ Alternate Phone #: _____

Patient's Address: _____

Primary Insurance: _____ Secondary Insurance: _____

Does patient's insurance require pre-authorization? Yes No

If YES, Pre-Auth# _____ Dates Pre-Auth. Is Valid: _____

PLEASE SEND INSURANCE REFERRAL/PRECERT INFORMATION IF REQUIRED.

Patient is Referred for:

- | | |
|---|---|
| <input type="checkbox"/> Myofascial pain (muscle pain) | <input type="checkbox"/> Lumbar facet arthropathy (low back joint pain) |
| <input type="checkbox"/> Cervical facet arthropathy (neck joint pain) | <input type="checkbox"/> Lumbar degenerative disc disease |
| <input type="checkbox"/> Cervical degenerative disc disease | <input type="checkbox"/> Back and leg pain |
| <input type="checkbox"/> Neck, shoulder and arm pain | <input type="checkbox"/> Sciatica (radicular pain) |
| <input type="checkbox"/> Occipital headaches | <input type="checkbox"/> Shingles (herpes zoster) pain |
| <input type="checkbox"/> Thoracic facet arthropathy (back joint pain) | <input type="checkbox"/> Complex regional pain syndrome (CRPS) |
| <input type="checkbox"/> Thoracic degenerative disc disease | <input type="checkbox"/> Reflex sympathetic dystrophy (RSD) |
| <input type="checkbox"/> Indicate procedure (if applicable) | <input type="checkbox"/> Cancer pain |
| | <input type="checkbox"/> Other (explain) _____ |

Studies Obtained:

MRI CT X-Rays Ultrasound Angiogram EMG/NCV Other: _____

Please Include The Following-We Cannot Schedule Without

PLEASE FAX COPIES OF ANY DIAGNOSTIC REPORTS (MRI, CT, X-RAY, ETC.), AS WELL AS THE MOST RECENT PHYSICIAN'S NOTES, PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION RELATED TO THE PATIENT ALONG WITH THIS REQUEST FORM. PLEASE SEND INSURANCE REFERRAL/PRECERT INFORMATION IF REQUIRED.

Please fax completed form to (540) 450-2333