REDDING
SPINE & SPORTS
MEDICINE

1945 Shasta Street – Redding, Ca – 96001 – Phone (530) 244-4608 – Fax (530) 247-1096

Date:_____ Patient:_____ Referring Provider:_____
Referring Fax:_____ Referring Phone:_____
Diagnosis:_____

Patient Address:_____ DOB:_____ SSN:_____
Insurance (Primary):_____ Secondary:_____ Phone#:_____

___ Physiatry Consult:

___ First available ___ Dr. Joseph Purcell ___ Dr. Annie Davidson Purcell

___ Referral to take over pain medication management

___ EMG/NCS: RUE LUE RLE LLE (Please circle)

___ Diagnostic/Therapeutic Injections (Fluoroscopically-guided):

___ Lumbar Epidural Steroid Injections
___ Caudal epidural
___ Diagnostic Selective Nerve Root Block – specify nerve:_____
___ Sacroiliac Joint: R L
___ Facet: ___ Joint injection ___ Diagnostic medial branch blocks
___ Radiofrequency neurolysis
Joints to block: ___ per Physiatry ___ Specific joints:_____
___ Other injection (specify):_____

___ Ultrasound-guided injections: (specify) _____

Please fax patient demographics including insurance information along with recent chart notes and studies.

Thank you!