



New Patient Referral Form

New Patient Referral Department Contact Information

Phone: (916) 953-7571 + Fax: (916) 860-7584 + [Email: newpatients@apdss.com](mailto:newpatients@apdss.com)

Referring Provider Information:

_____ Provider Name	_____ Provider NPI	_____ Practice Name	
_____ Practice Contact Name	_____ Phone #	_____ Fax #	_____ Email

Patient Information:

_____ Patient Name	_____ DOB	_____ Phone #	_____ Email
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Patient Address, City, State, Zip

Insurance Type Workers' Compensation Medicare Managed Medi-Cal Med-Pay
(check one) Commercial PPO/HMO Managed Medicare Personal Injury Lien Other__

_____ Primary Insurance Carrier or Administrator Name	_____ Patient ID or Claim #	_____ Group # or Date of Accident/Injury
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_____ Claims Adjuster Name (if applicable)	_____ Claims Adjuster Phone #, Fax # and Email (if applicable)
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_____ Attorney Name (if applicable)	_____ Attorney Phone #, Fax # and Email (if applicable)
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Diagnosis & Services Requested:

Primary Diagnosis Description:

(Please Check one):

<input type="checkbox"/> Consultation Only	<input type="checkbox"/> EMG/Nerve Conduction Study <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Procedure only
<input type="checkbox"/> Consultation continued mgmt.	<input type="checkbox"/> Upper Extremity	<input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar
	<input type="checkbox"/> Lower Extremity	<input type="checkbox"/> Epidural Steroid Injection
		<input type="checkbox"/> Facet Joint Injection
		<input type="checkbox"/> Nerve Ablation
		<input type="checkbox"/> Spinal Cord Stimulator
		<input type="checkbox"/> Plasma Rich Platelet (PRP) Injection
		<input type="checkbox"/> Stem Cell Injection
		<input type="checkbox"/> Other: _____



New Patient Referral Documentation Requirements

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The following documents are required in order to effectively review and consult on prospective patient care involving pain management, as well as to responsibly deliver that care, if called on to do so.

Patients will not be scheduled until all requested documents have been provided.

- New Patient Referral Form
- Copy of Your Signed Medical Records Release Form (for any records held at other offices or facilities)
- Insurance authorization, if required
- List of current medications
- Diagnostic imaging from the past two years (i.e. X-Rays, MRI, CT-Scans)
- Chart notes from the last 3 visits
- Lab results pertaining referred condition (i.e. urine drug screens)
- Physical therapy evaluation notes from the past two years

Note: We are currently closed to new methadone patients.

Please fax all these documents to: **(916) 860-7584**

If by mail: Advanced Pain Diagnostic & Solutions
 Attn: New Patient Referral Department
 729 Sunrise Ave, Ste 607
 Roseville, CA 95661

Thank you,

New Patient Referral Department