Mark A. Ellis, M.D.
Board Certified Pain Management Specialist
Medical/Lab Director

Terrance L. Hughes, M.D.
Board Certified Pain Management Specialist
Board Certified Physical Medicine & Rehabilitation

REFERRAL FORM

Patient Name ______________________________ DOB ______________

Patient Phone Number ______________________________

Diagnosis ______________________________

Appointment Date ______________________ Time ______________ ❑ am ❑ pm

EVALUATION FOR:

- ❑ EVALUATE AND TREAT
- ❑ EPIDURAL(s)
- ❑ DISCOGRAPHY
- ❑ NERVE BLOCKS
- ❑ INDEPENDENT MEDICAL EXAM
- ❑ MEDICAL MANAGEMENT
- ❑ SPINAL CORD STIMULATOR
- ❑ OTHER ______________________________

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Please attach demographics and recent clinical and imaging information.

Requesting Physician ______________________ Date ______________

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