SPINE INSTITUTE OF CENTRAL FLORIDA
WORLD-CLASS SPINE CARE
EXCELLENCE IN MINIMALLY INVASIVE SPINE SURGERY
Comprehensive Center of Excellence in ALL Spine Care & Pain Management

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Excellence in Minimally Invasive Spine Surgery

We are Experts in ALL Non-Surgical & Surgical Treatments of Neck, Back Pain & ALL Spinal Disorders

- **Herniated Discs**
- **Lumbar Stenosis**
- **Complex Reconstructive Spine Surgery**
- **Pediatric Scoliosis**
- **Adult Scoliosis**
- **Cervical/Thoracic/Lumbar/ Sacral Spine Disorders**
- **Degenerative Spine Disorders**
- **Spinal Cord Stimulators**
- **Failed Prior Spine Surgery**
- **Total Disc Replacements**
- **Spinal Surgical Oncology**
- **Radiofrequency Tumor Ablation**
- **Interventional Pain Management**
- **Neurodiagnostic Spinal Injections**
- **Epidural Injections**
- **Spinal Cord Trauma & Unstable Spinal Fractures**
- **Vertebral Compression Fractures**
- **Kyphoplasty/Vertebroplasty**
- **Innovative/Specialized Spinal Rehabilitation Programs**
- **Auto Accidents**

MRI & Advanced Imaging are **NOT Required** Prior to Referrals.

Expedited Patient Scheduling. New patients can ALWAYS be seen within 2-3 weeks. Much sooner (within 24 hours) for Spinal Fractures, Trauma, Emergencies, Injuries or Urgent Consultations.

Second Best is NOT an Option When it Comes to Your Patient's Spine Needs

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PATIENT REFERRAL FORM

Date:_____

_____ Schedule Next Available
_____ Schedule Emergently

_____ Pediatric Patient
_____ Adult Patient

PLEASE FAX COMPLETED FORM TO (863)688-4430

NOTE: please remind patients to bring hard copies of any pre-existing relevant imaging studies and reports (i.e. X-Rays, MRI, CT). It is not necessary to delay patient's appointment scheduling in order to obtain new imaging studies.

REFERRING PROVIDER'S INFORMATION

Referring Physician/Provider Name:_____

Phone:_____**Fax:**_____

PATIENT'S INFORMATION

Patient Name:_____ **D.O.B:**_____

Phone #:(_____)_____ Patient's Alternative #: (_____)_____

Insurance Type (i.e. Medicare/Allstate/BCBS):_____

What type of Symptoms does this patient have?

_____Neck pain, headaches, and/or pain radiating to arm(s), shoulder(s), or upper back
_____Mid-thoracic pain with or without radiation around chest wall
_____Low back pain with or without radiation to leg(s), or hip(s)
_____Structural spinal deformity e.g. Scoliosis or Kyphosis
_____Spinal/Vertebral tumor or Metastatic Cancer to the Spine
_____Spinal or Vertebral Compression Fractures
_____Auto Accident
_____Other:_____

Please indicate if ANY of the following BELOW are applicable:

❖	**Impairment of Bladder/Bowel Function**	**YES**	**NO**
❖	**Saddle Anesthesia**	**YES**	**NO**
❖	**Gait Disturbance**	**YES**	**NO**
❖	**Supine/Night Pain**	**YES**	**NO**
❖	**Weight Loss**	**YES**	**NO**
❖	**Acute Onset of Severe or Intractable Radiculopathy**	**YES**	**NO**
❖	**Progressive or New Onset Extremity Weakness**	**YES**	**NO**
❖	**Severe Limitations (Example in Lumbar Flexion)**	**YES**	**NO**

IF THE ANSWER IS YES TO ANY OF THE ABOVE,

PLEASE REQUEST EMERGENCY SCHEDULING.