Osteoarthritis of Knee

Referral Form

Is knee pain keeping your patients up at night?

Please fax this form to:

951-574-6501

Patient Name:____**DOB:** __________________

Tel Number: __________________________ **Caretaker Name:**________________________

Clinical Information:	Both Knee	Right Knee	Left Knee
Knee Pain			
Knee Stiffness			
Knee Pain limiting physical activity			
Is Patient on Pain medications for knee pain			
Has patient had knee injections			
Has patient had knee surgery			

Diagnosis Code:

____M17.0 Both Knees

____M17.11 Right Knee

____M17.12 Left Knee

Referral for:

___ Knee Pain Evaluation with possible Genicular Artery Embolization (GAE)

Please Include the following with your fax:

___ Referral Form (This Form) ___ Patient ID (Drivers license) ___ Patient Demographics

___ Patient Insurance Card ___ Last Office visit note. ___ Recent Lab's, X-rays, MRI

This is a referral for consultation. If the consultation findings require further evaluation and treatment by the physician or Physician extender including but not limited to additional tests or procedures this shall serve as my written referral.

Physician Name:____________________________________ Date:____________________

Physician Signature:_________________________________ TAX ID:__________________

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