



INTERVENTIONAL SPINE CARE & ORTHOPEDIC REGENERATIVE EXPERTS

info@SCOREINC.COM

Referral Form

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51 N. 5th Ave, #301
Arcadia, CA 91006

317 S. Brand Blvd., Suite 103
Glendale, CA 91204

Please complete the form, then fax/e-mail along with the last office note, EMG/NCS, MRI, and any other pertinent imaging studies. Our Office will contact the patient for an appointment.

You may also call our office directly. Office Hours: 9:00 am to 5:00 pm.

Maxim Moradian, MD, QME, DABPMR, CAQSM, DABPM, DABRM

Revik Vartanian, DO, DABPMR

Patient Information:

Patient Name: _____ D.O.B. ____/____/____

SS# _____ Phone#: _____

E-mail: _____

Address: _____ City: _____ Zip: _____

Patient Insurance: _____

(Please include copy of front & back of insurance, Driver's insurance)

Referring Diagnosis: _____

Testing (Past 6 Months): _____

X-Ray MRI CT Scan EMG/NCS Ultrasound Other: _____

(Please include copy of testing reports if possible)

Referring Provider's Name: _____

Referring Provider Ph: _____ E-mail: _____ Fax# _____

Office Contact Person: _____ Sender's Name _____

Please Check Preferences:

Consult & Treat Consult & Return with Recommendations Electrodiagnostic Testing (EMG/NCS)

Injection Series (Must complete the Following) Spinal Cord Stimulation Consult

Lumbar Level(s) _____

Circle One: (Left • Right)

Cervical Level(s) _____

Bilateral Circle One: (Left • Right)

Thoracic Level(s) _____

Bilateral Circle One: (Left • Right)

Nerve Block Level(s) _____

Bilateral Circle One: (Left • Right)

Joint Specify: _____

Bilateral

After injection, patient to follow up with: Referring Provider iSCORE