



iSCOREINC.COM

# Referral Form

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

317 S. Brand Blvd., Suite A-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

James J Lieu, 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