Southern Oregon
SPINE CARE

New Patient Referral Form

Fax to: (541) 779-5022

Today's Date: ___________________

Patient Name: _____________________________________ Patient's DOB: ___________________________

Physician referred to:

☐ Dr. Mark Peterson, MD ☐ Dr. Erik Olsson, MD
☐ Tom Trubenbach, NP ☐ Chris Weinman, PAC ☐ Per Provider discretion

Referring Physician: _________________ Phone number: ______________ Fax number: ________________

Has this patient been seen by another:

1. Spine physician? Y / N If yes, Doctor: ________________________ Date(s):___________________
2. Pain management clinic? Y / N If yes, Doctor: _________________ Date(s): ___________________

Does the patient have any diagnostic studies? (i.e. x-rays, MRI, CT, EMG, DEXA, etc. If yes, where:

____

____

Reason for Referral

☐ Back Pain
☐ Neck Pain
☐ Arm Pain
☐ Leg Pain
☐ Other: _____________________

Priority

☐ Urgent*
☐ Routine

*If Urgent, please provide more detail: __________________
____

**** Please send patient demographics along with any chart notes and/or diagnostic reports pertinent to patient's visit.**

*Please allow up to 48 hours processing time once all the information is received an on all routine referrals.

The information below will be faxed back to the number given about for patient file.

Appointment Date: ____________________ Time: _______________ Physician: ________________________