REFERRAL FORM for
Maia U. Chakerian, M.D.
PAIN MEDICINE SPECIALIST

14601. S. Bascom Ave., Ste. 240
Los Gatos, CA 95032
Tel 408-356-0503
Fax 408-356-4704

PATIENT NAME ________________________________ TELEPHONE _________________

D.O.B: _______________

Date/s needed: ____

Fax all requested documents AND this completed form to:
(408) 356-4704

REQUESTING DOCUMENTS

1. PATIENT DEMOGRAPHICS and COPY OF INSURANCE CARD(S)
2. PERTINENT CHART NOTES TO INCLUDE MRI/XRAY/LAB/OP REPORTS, ETC.
3. REASON FOR REFERRAL (see below)

Please call **408-356-0503** to confirm the receipt of this fax. Once we have received all of these documents, the records will be reviewed, and your patient will be contacted.
Thank you for your referral!

INSURANCE INFORMATION:

- ☐ PPO ______________
- ☐ SCCIPA AUTH # _________________
- ☐ MEDICARE
- ☐ SELF

REASON FOR REFERRAL:

- ☐ EPIDURAL BLOCK
- ☐ TRIGGER POINT INJECTION
- ☐ OTHER INJECTION _____________________
- ☐ DISCOGRAPHY
- ☐ BOTOX
- ☐ MEDICATION EVALUATION
- ☐ OTHER _____________________________

DIAGNOSIS:

- ☐ LUMBAR DISC DISEASE/STENOSIS
- ☐ CERVICAL DISC DISEASE/STENOSIS
- ☐ POSTLAMINECTOMY SYNDROME
- ☐ RSD/CRPS
- ☐ ARTHRITIS PAIN
- ☐ HEADACHE
- ☐ MUSCLE PAIN
- ☐ NEUROPATHY
- ☐ CANCER PAIN
- ☐ LOW BACK PAIN
- ☐ NECK PAIN
- ☐ ABDOMINAL/PELVIC PAIN
- ☐ SHINGLES/PHN
- ☐ CHEST PAIN
- ☐ OTHER ____