



Amr Hosny, MD, MBA
Medical Director
Board Certified
Interventional Pain Specialist

Riverdale One Building
44 Route 23 North
Riverdale, NJ 07457

Phone 973.400.1716
Fax 973.400.1631
www.NJPCC.com



FAX REFERRAL

Date: _____

Patient Information: _____

Name: _____ DOB: _____

Phone #: _____ Patient SSN: _____

Chief Complaint: _____

Referring Physician: _____

Referring Physician Phone #: _____ Fax #: _____

Referring Physician NPI #: _____

Referring Physician Address: _____

- Evaluation Only
- Evaluate & Treat

Insurance Carrier: _____

Special Instructions: _____

Please fax copy of referral form and any applicable medical records.
Patient should bring MRI and/or plain films to consult visit.



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FAX REFERRAL

Name: _____ Date: _____

DOB: _____ Home Phone #: _____ Work Phone #: _____

Chief Complaint/Diagnosis: _____

*** PLEASE FAX COPIES OF ANY DIAGNOSTIC REPORTS (MRI, CT, X-RAY, ETC.), AS WELL AS THE MOST RECENT PHYSICIAN'S NOTES, PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION RELATED TO THE PATIENT ALONG WITH THIS REQUEST FORM. ***

<input type="checkbox"/> Pain Evaluation & Consultation	<input type="checkbox"/> Nucleoplasty (Percutaneous)
<input type="checkbox"/> Diagnostic Nerve Block	<input type="checkbox"/> IDET Procedure
<input type="checkbox"/> Epidural Steroid Injection ___cervical ___thoracic ___lumbar	<input type="checkbox"/> Lumbar Sympathetic Block
<input type="checkbox"/> Facet Joint injection ___cervical___thoracic___lumbar	<input type="checkbox"/> Occipital Nerve Block
<input type="checkbox"/> Selective Nerve Root Block ___cervical___thoracic___lumbar	<input type="checkbox"/> Stellate Ganglion Block
<input type="checkbox"/> Discography ___thoracic___lumbar	<input type="checkbox"/> Trial Spinal Cord Stimulator
<input type="checkbox"/> Botox Treatment for Maxillofacial Pain, Migraines and TMJ	<input type="checkbox"/> Facet Rhizotomy
<input type="checkbox"/> Specific Level Desired (If applicable): _____	<input type="checkbox"/> Intrathecal Pump/Trial/Refill ___Morphine ___Baclofen ___other
OTHER: _____	

Referring Physician: _____

Referring Physician NPI #: _____ Contact Telephone: _____