**TO: PAIN DIAGNOSTICS AND TREATMENT CENTER, P.A.**
7777 Forest Lane, Suite C-502 2241 Peggy Lane, Suite A
Dallas, TX 75230 Garland, TX 75042
Ph: 972-566-8999 **Fax: 972-566-8998**

**DATE:**_____

**TIMOTHY N. ZOYS, M.D.**

**FROM:**
Requesting Physician:_____ Specialty:_____

Address:_____ City:_____ State/Zip:_____

Office Phone#:_____ Office Contact:_____ UPIN#:_____

**SERVICE REQUESTED:** (Check one)

☐ Consult with Procedure (if necessary) ☐ Evaluate and Treat

☐ Consult only ☐ Other:_____

☐ Referral for Procedure (specify below)

**PROCEDURE ONLY:** (Check)

☐ Facet Injection(s) ☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Caudal

☐ Epidural Steroid Injection Level(s):_____

☐ Selective Nerve Root Injection ☐ Right ☐ Left

☐ Sacroiliac Joint Injection

☐ Other:_____

Special instructions:_____

**DIAGNOSIS**: 1) _____ 2) _____

3) _____ 4) _____

**CONFIRMATORY TESTING:** ☐ CT ☐ MYELOGRAM ☐ MRI ☐ EMG/NCV ☐ X-RAY

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Patient Name:_____ SS#:_____

Address:_____ City:_____ State/Zip:_____

Home Ph#:_____ Work Ph#:_____ DOB:_____

**BILLING INFORMATION** **(copy of insurance face sheet or insurance card is acceptable)**

| | | | |
|---|---|---|---|
| Insurance Carrier: | | Adjuster Name: | |
| Insurance Co. Phone #: | | Place of Employment: | |
| Policy Holder's Name: | | Employer's Phone#: | |
| Policy Number: | Group Number: | W/C Claim#: | Date of Injury: |

**PLEASE FAX COPY OF H&P / SUMMARY AND RECENT PROGRESS NOTES**