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: ________________

Referring Physician/Phone: ____

INSURANCE INFORMATION:

- € PPO _________________(We are IN Network with United Healthcare, Cigna, HealthNet and Aetna PPO's. We are OUT of network with Blue Cross and Blue Shield PPO's.)
- € SCCIPA AUTH # _____________________
- € MEDICARE
- € SELF-PAY

REASON FOR REFERRAL:

- € EPIDURAL BLOCK
- € TRIGGER POINT INJECTION
- € OTHER INJECTION _________________________
- € DISCOGRAPHY
- € BOTOX
- € Spinal Cord Stimulator
- € Spinal Pump
- € OTHER ___________________________________

DIAGNOSIS:

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

ADDITIONAL REQUIRED DOCUMENTS:

1. **PATIENT DEMOGRAPHICS and COPY OF INSURANCE CARD(S)**
2. **PERTINENT CHART NOTES (e.g. LAST 3 NOTES)**
3. **MRI/XRAY/LAB/OP REPORTS, ETC.**

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

Thank you for your referral!