Barr Center
for Innovative Pain & Regenerative Therapies
www.BarrCenter.com

PATIENT REFERRAL FORM

PHONE: 757-578-2260 FAX: 757-578-2261

LISA BARR, MD
MORGAN ROGERS, NP
LESLIE HODEEN, NP
JANET HARE, PT
CARMEN CELLON, PT

Patient's Name:		Male Female	D.O.B.
Home Phone:	Work Phone :	Ext:	Cell Phone:
Insurance:	Policy Number:		
Diagnosis:		ICD 10:	
Referring Physician:	Contact Person:	Office #:	Fax #:

CONSULTATION, TESTING, TREATMENT

Physiatric Consultation
Diagnostic Ultrasound (Musculoskeletal): Area:
Physical Therapy Evaluation/Treatment (Please attach script)
Balance Clinic Evaluation/Training
Regenerative Medicine Consult

PROCEDURES *(HUMANA insurance requires prior consultation)*

Epidural Steroid Injection:		Area:	
Facet Joint Injections:		Area:	
Sacroiliac Injections:			
RadioFrequency Ablation (Requires Previous Diagnostic Blocks):			Area:
Image Guided Injections:	Fluoroscopic	Musculoskeletal Ultrasound	Area:
Lumbar Discography:		Levels:	
Spinal Cord Stimulator Trial:		Area:	
Botox Injection (Consultation Required):		Area:	
Prolotherapy:		Area:	
Regenerative Medicine: **(Requires Consultation)**:			
Platelet Rich Plasma (PRP):		Area:	
Bone Marrow Concentrate:		Area:	

For Barr Center Office Use Only:

Dr. _____ ***Appointment Date:*** _____ ***Appointment time:*** _____

☐ *Attempted to contact patient - NO RESPONSE* ☐ *Not scheduled after medical review*

Comments:

PLEASE ATTACH THE FOLLOWING INFORMATION:

- Referral, if required
- Copy of insurance card/WC claim information
- Patient Demographics
- Recent Office Notes
- MRI/CT Report (Mandatory for all procedures)