The Diagnostic and Injury Center of Houston, LLC.

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Houston, Texas 77065
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Fax (281) 890-2625

Referral/Consultation Request

Patient Name:_____

Patient's Home Phone:_____ Work Phone:_____

Cell Phone:_____

Appointment Date:_____ Appointment Time:_____

☐ Orthopedic Exam/Consult
☐ Permanent Impairment Examination
☐ Second Opinion Examination
☐ Independent Medical/Chiropractic Examination
☐ Medical Management Examination
☐ Patient Chart/File/Billing Audit
☐ Radiographic Examination - Area(s)_____
☐ EMG/NCV – Area(s)_____
☐ Trigger Point Injection(s) – Area(s)_____
☐ Spinal Block(s) – Area(s) _____
☐ Joint Injection – Area(s) _____
☐ Laboratory – Blood/Urine Study

Examination Requested _____

_____

Clinical Findings_____

_____

Diagnosis – ICD-9_____

Referring Doctor/Physician_____

Phone #:_____ Fax #:_____

E-Mail _____

Attorney (if applicable):_____

Phone #:_____ Fax #:_____

E-Mail _____

☐ Call With Report ☐ Fax Report ☐ Copy of Films

- Consult/Exam Patients – Please bring all prior x-rays, MRI, CT, EMG/NCV or any other diagnostic tests or reports and films with you to your appointment.