Mark J. Sontag, M.D.
Sports, Spine and Electrodiagnostic Medicine
Diplomate, Board of Physical Medicine and Rehabilitation
Diplomate, American Association of Neuromuscular & Electrodiagnostic Medicine
Qualified Medical Evaluator

Susan G. Kritzik, M.D.
Physical and Occupational Medicine
Diplomate, Board of Internal Medicine

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☐ **Mark J. Sontag, M.D.** ☐ **Susan G. Kritzik, M.D.** ☐ **David F. Smolins, M.D.**
☐ **Diane Hafner, D.C.** ☐ **Elaine S. Date, M.D.** ☐ **First Available**

Patient Name: ______________________________ Today's Date: _____ -- _____ -- _____

Best number to contact patient :(_____) _____ - __________ Date of Birth: _____ --_____-- _____

Referring Physician (print) ______________________________ Phone #(_____) __________ -- __________

Diagnosis: ____

Please send the following documents with this referral form & check those sent:

☐ Patient Demographics ☐ Most recent progress notes or procedures. ☐ MRI report or diagnostic studies
☐ Insurance (copy of both sides of cards) ☐ Required Authorization
(Send all Worker's Compensation information) (Worker's Compensation required written authorization)

Reason For referral

Check one Box:

☐ Consult only ☐ Evaluate & Treatment ☐ Procedure only
(Complete section below)

Surgery Center

☐ Cervical ☐ Left ☐ Epidural Steroid Inj. ☐ Sympathetic Block ☐ Radiofrequency Ablation
☐ Thoracic ☐ Right ☐ Medial Branch Block ☐ Selective Nerve Root Block ☐ Hip ☐ Shoulder ☐ Sacroiliac
☐ Lumbar ☐ Bilateral ☐ Facet Joint Injection ☐ Spinal Cord Stimulator ☐ Discography
☐ Other: ____________________ Procedure Levels: ______________________________

Office

☐ EMG/NCV (bilateral studies are always done)
☐ Trigger Point Injections ☐ Botox
☐ Chiro Care w/Diane Hafner, D.C_______visits
☐ Acupuncture
☐ Joint Injection
☐ QME (Qualified Medical Exam)
☐ AME (Agreed Medical Exam)
☐ IME (Independent Medical Exam)
☐ Functional Restoration Program /Evaluation
☐ Other:

Referring M.D. Comments: ____

____

Referring M.D. Signature: ______________________________ Date: ____________________

This can be faxed to (650) 306-0250 ***Thank You for your referral***

Office use only: Appointment confirmation
Date: ____/____/____ Day: ____________ Time: ______________ W/ ____________________________ M.D.

Team Spine & Pain Consultants for the
Oakland Raiders, San Jose Sharks, and San Jose Sabercats