spine & sport care

Michael J. Simek, MD
Board Certified Physical Medicine and Rehabilitation
Subspecialty in Sports Medicine
Fellowship Trained in Interventional Spine

PHYSICIAN REFERRAL FORM

Patient Information:

Name: ______________________ Date of Birth: __________ Sex: M F

Phone: ______________ Address: ______________________________

Medical Insurance: ______________________________

Referring Physician Information:

Physician Name: ______________________________

Practice Name: ______________________________

Address: ______________________________

Phone: ______________________ Fax: ______________________

Reason for Consultation:

☐ Consult Only ☐ Consult and Treat ☐ Back Pain ☐ Neck Pain ☐ Joint Pain

☐ Eval for Injection ☐ Radiculopathy ☐ Other

☐ EMG/NCS ___ *left* ___ *right* ___ *bilateral*

___ *upper* ___ *lower*

Clinical Description:

____

____

Physician Signature: ______________________________

☐ 501 West Schrock Road
Suite 103
Westerville, OH 43081

☐ 3823 Trueman Court
Hilliard, OH 43026

☐ 117 West High Street
Suite 108
London, OH 43140

Please send this form along with supporting medical records to:

American Health Network - physical medicine & rehabilitation
Michael J. Simek, MD
501 West Schrock Road, Suite 103
Westerville, OH 43081

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