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Date: _____ Patient: _____

SS#: _____ DOB: _____

Phone: _____ Insurance Co: _____

Diagnosis/ Symptoms: _____

Allergic to penicillin: ____ Yes ____ No

____ Please evaluate and treat the patient.

____ Please perform the following procedure: _____

Fast Track Patients (same or next day injection) please make sure the patient is:

- NPO 6 hours before appointment.
- Send MRI films and/or report, if available.
- Inform patient they must have a driver.

____ Return to me for follow up ____ Follow up by Advanced Pain Centers of AK

Referring provider name (print)

Referring provider signature

Referring provider address, telephone and fax number

To expedite this referral please include the following information: demographics, chart notes, and x-ray/MRI reports.

Wasilla
3035 E. Palmer-Wasilla Hwy, Unit 501
Wasilla, AK 99654
(907) 357-8330 telephone
(907) 357-8377 facsimile

Anchorage
1917 Abbott Road, Suite 100
Anchorage, AK 99507
(907) 278-2741 telephone
(907) 743-8284 facsimile

Fairbanks
1275 Sadler Way, Suite 101
Fairbanks, AK 99701
(907) 374-6602 telephone
(907) 374-6604 facsimile