REFERRAL REQUEST

Grant T. Roderer, M.D.● Lawrence W. Stinson, M.D
Joanie Randle, PA-C

Date:_____ Patient: _____

SS#: _____ DOB: _____

Phone:_____ Insurance Co:_____

_____ Please evaluate and treat the patient.
_____ Please perform the following injection: _____
_____
_____
_____

Allergic to penicillin: _____Yes _____No Blood thinners: _____Yes _____ No

"Injections Only" Please forward current H&P, Radiology Report, and Medication / Allergy list. Patient is required to bring actual imaging to their first appointment.

Diagnosis/ Symptoms: _____
_____
_____
_____

_____ Return to me for follow up _____ Follow up by APCA

_____ _____
Referring provider name (print) Referring provider signature

_____ _____
Phone Number Fax Number

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Anchorage, AK 99507
(907) 278-2741 telephone
(907) 743-8284 facsimile