Illinois PAIN & SPINE INSTITUTE

PATIENT REFERRAL FORM

Date:_____

First Name:_____ Last Name:_____

DOB:_____ Phone Number:_____

Insurance (please include copy if available):_____

Referral for:
- ☐ Dr. John Prunskis, M.D., FIPP
- ☐ Dr. Chadi Yaacoub, M.D., FIPP.
- ☐ Dr. Hadi Moten, M.D., M.S.
- ☐ Dr. Terri Dallas-Prunksis, M.D.
- ☐ Dr. Todd Hagle, M.D., FIPP
- ☐ No Preference, First Available

☐ Work related injury? ☐ Is the injury related to a Motor Vehicle Accident?

Diagnosis:

- ☐ Abdominal Wall Pain
- ☐ Back Pain
- ☐ Cancer Pain
- ☐ Chest Wall Pain
- ☐ Chronic Prostatitis
- ☐ CRPS/RSD
- ☐ Head and Neck Pain
- ☐ Headache Pain
- ☐ Herniated Disc Pain
- ☐ Hip and Joint Pain
- ☐ Interstitial Cystitis
- ☐ Facial Pain
- ☐ Myofascial Pain
- ☐ Pelvic Pain
- ☐ Peripheral Nerve Disorders
- ☐ Phantom Limb Pain
- ☐ Post-Myelogramor or Spinal Headache
- ☐ Post-Surgical Pain
- ☐ Post-Surgical Scar Pain
- ☐ Post-Traumatic Pain
- ☐ Sciatica
- ☐ Shoulder and Arm Pain
- ☐ Sports Injuries
- ☐ Vertebral Compression Fracture

Other Diagnosis/Treatment Reasons:

_____

_____

Referring Physician:_____

Office Phone:_____ Office Fax:_____

Please attach copies of all diagnostic reports performed in the last year (MRI, CT, X-RAY, Bloodwork), as well as most recent physician note and patient demographic along with this form to (847) 289-0815.