

Injury Care Network, LLC

Provider **WALLACE, D.O.**

Patient **ANGEL, THEODORE**

DOB **09/15/1975** DOL **02/23/2023**

DOS **08/11/2023**

REFERRAL

☐ **AURORA:** 14111 E. Alameda Avenue | Suite 200 | Aurora, CO 80012 P: (303) 343-1357 | F: (303) 343-3036
☒ **THORNTON:** 8515 Pearl Street | Suite 100 | Thornton, CO 80229 P: (303) 630-0400 | F: (303) 630-0405
☐ **DENVER:** 1250 Sheridan Blvd. | Denver, CO 80232 P: (303) 927-7119 | F: (303) 568-9331

DIAGNOSES:

DISCHARGED ☒

1. L5 radiculopathy R
2. L5-S1 disc herniation
3. (R) buttock pain
4. _____
5. _____
6. _____

RECORDS REQUESTED:

- | | | |
|---|--|--|
| <input type="checkbox"/> St. Anthony's Central | <input type="checkbox"/> Good Samaritan Medical Center | <input type="checkbox"/> Denver Health |
| <input type="checkbox"/> University Hospital | <input type="checkbox"/> North Suburban Medical Center | <input type="checkbox"/> St. Anthony North |
| <input type="checkbox"/> Swedish Medical Center | <input type="checkbox"/> Littleton Adventist Hospital | <input type="checkbox"/> Kaiser Permanente |
| <input type="checkbox"/> Sky Ridge Medical Center | <input type="checkbox"/> Lutheran Medical Center | <input type="checkbox"/> St. Joseph's Hospital |
| <input type="checkbox"/> Medical Center of Aurora | <input type="checkbox"/> Rose Medical Center | <input type="checkbox"/> Porter Adventist Hospital |
| <input type="checkbox"/> Children's Hospital | <input type="checkbox"/> Specialist: _____ | <input type="checkbox"/> PCP: _____ |
| <input type="checkbox"/> Other: _____ | | |

REFERRAL FOR ADDITIONAL SERVICES (IN OFFICE):

- | | |
|--|--|
| <input type="checkbox"/> Physical Therapy: Evaluate and Treat | <input checked="" type="checkbox"/> Chiropractic: Evaluate and Treat |
| <input type="checkbox"/> PT-Vestibular | <input checked="" type="checkbox"/> Massage Therapy |
| <input type="checkbox"/> Acupuncture: Evaluate and Treat | <input type="checkbox"/> Neuropsych Eval |
| <input type="checkbox"/> Psychology <input type="checkbox"/> Driving Anxiety <input type="checkbox"/> Biofeedback <input type="checkbox"/> TBI | <input type="checkbox"/> Occulogica - EyeBox 1 <input type="checkbox"/> 2 <input type="checkbox"/> |
| <input type="checkbox"/> BrainView: Evaluate and Treat <input type="checkbox"/> DANA | <input type="checkbox"/> Assess for Trigger Point |
| <input type="checkbox"/> BrainCheck 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> | <input type="checkbox"/> Regenerative Medicine-PRP <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder |
| <input type="checkbox"/> BrainCheck Anxiety/Depression 1 <input type="checkbox"/> 2 <input type="checkbox"/> | <input type="checkbox"/> DO/MD Medication Eval |
| <input type="checkbox"/> BrainCheck Vision 1 <input type="checkbox"/> 2 <input type="checkbox"/> | <input type="checkbox"/> Other: _____ |

RESTRICTIONS OR SPECIAL INSTRUCTIONS:

Muscle skin unit

REFERRAL FOR ADDITIONAL SERVICES (OUTSIDE OFFICE):

- | | |
|---|---|
| <input type="checkbox"/> Spine Surgeon | <input checked="" type="checkbox"/> Injection Specialist <u>11-9-23</u> |
| <input type="checkbox"/> Pain Specialist Consultation | <input type="checkbox"/> Dentist/TMJ Specialist |
| <input type="checkbox"/> Physiatrist | <input type="checkbox"/> Hand Specialist |
| <input type="checkbox"/> General Surgeon | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Podiatrist Surgeon | <input type="checkbox"/> Neuro Optometrist |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Orthopedic Consultation for: _____ | |

REFERRAL FOR DIAGNOSTIC STUDIES:

- ☐ MRI/Type: _____ C-Spine Flex/Ext ☐ 3T/TBI ☐ DTI ☐ SWI ☐ NeuroQuant ☐
- ☐ CT: _____
- ☐ Other: _____ (VNG, Ultrasound, Labs, Etc.)
- ☐ X-Rays: _____

Follow up in _____ weeks. Next appointment is scheduled for _____/_____/_____ at _____ : _____ AM/ PM.

(PROVIDER)

(DATE)