

Injury Care Network, LLC

Provider **WALLACE D.O.**
Patient **ANGEL, THEODORE**
DOB **09/15/1975** DOL **02/23/2023**
DOS **03/10/2023**

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:

1. Concussion
2. C-T-L Strain
3. bilat - shoulder strain

DISCHARGED

4. RT leg pain
5. HA
6. Anxiety

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 checked="" 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 checked="" type="checkbox"/> Acupuncture: Evaluate and Treat	<input type="checkbox"/> Neuropsych Eval <input type="checkbox"/> Cognitive Screening
<input checked="" type="checkbox"/> Psychology <input checked="" type="checkbox"/> Driving Anxiety <input type="checkbox"/> Biofeedback <input type="checkbox"/> TBI	<input type="checkbox"/> Occulogica - EyeBox
<input type="checkbox"/> Neuro Optometrist	<input type="checkbox"/> Consult for Delayed Healing <input type="checkbox"/> Assess for Trigger Point
<input type="checkbox"/> Podiatrist	<input type="checkbox"/> Regenerative Medicine - PRP <input type="checkbox"/> Knee <input type="checkbox"/> Shoulder
<input type="checkbox"/> BrainCheck 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/>	<input type="checkbox"/> DO/MD Medication Eval
<input type="checkbox"/> BrainCheck Anxiety/Depression 1 <input type="checkbox"/> 2 <input type="checkbox"/>	<input type="checkbox"/> Other: _____
<input type="checkbox"/> BrainCheck Vision 1 <input type="checkbox"/> 2 <input type="checkbox"/>	

RESTRICTIONS OR SPECIAL INSTRUCTIONS:

REFERRAL FOR ADDITIONAL SERVICES (OUTSIDE OFFICE):

<input type="checkbox"/> Spine Surgeon	<input type="checkbox"/> Injection Specialist
<input type="checkbox"/> Pain Specialist Consultation	<input type="checkbox"/> Dentist
<input type="checkbox"/> TMJ Specialist	<input type="checkbox"/> Hand Specialist
<input type="checkbox"/> General Surgeon	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Podiatrist Surgeon	
<input type="checkbox"/> Orthopedic Consultation for: _____	
<input type="checkbox"/> Neurologist	

REFERRAL FOR DIAGNOSTIC STUDIES:

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

Follow up in 2 weeks. Next appointment is scheduled for 3/23/23 at 10:00 AM/PM.

(PROVIDER)

(DATE)