TRANSACTION REPORT

MAR/24/2023/FRI 11:13 AM

FAX(TX)

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PLEASE SEND ALL CLINICAL NOTES

TAX ID #20-5633472

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- ☐ **WEST LITTLETON** P | 303-500-5252 F | 303-500-5272

SYNERGY HEALTH PARTNERS

- ☐ **AURORA** 14111 East Alameda Avenue, #200 Aurora, CO 80012 P | 720-410-5237
- ☐ **DENVER** 1262 South Sheridan Boulevard Denver, CO 80232 P | 303-927-7119
- ■ **THORNTON** 8515 Pearl Street, #100 Thornton, CO 80229 P | 303-630-0400

PLEASE BILL MANAGEMENT SYSTEMS

PATIENT DEMOGRAPHICS

Patient Name Theodore Angel DOB 09/15/1975

Primary Phone 720-461-0920 Height 5'7 Weight 215 lbs

■ Management Systems of Colorado ☐ Med Pay ☐ Self-Pay ☐ Health Insurance: _____

Auth # (if needed) _____ Insurance Carrier _____ Claim # _____

MVA/Premise Liability/Work Comp DOI 02/23/2023 Adjuster # 303-630-0400 Alme

PROVIDER INFORMATION

■ **MRI** Lumbar Spine & Cervical Spine

Special Protocol Needs: ☐ 3T / TBI ☐ DTI ☐ SWI ☐ NeuroQuant – General Morphometry Report & Traumatic Brain Atrophy ☐ Cervical Flexion & Extension ☐ Obliques through Spinal Foramen

Contrast: ■ Without ☐ With & Without ☐ At Radiologist Discretion

☐ **X-Ray** _____

Special Protocol Needs: ☐ Flexion & Extension ☐ L5-S1 Spot ☐ Obliques ☐ Odontoid ☐ Weight Bearing

Location: ☐ Left ☐ Right ☐ Both (If applicable)

☐ **CT** _____

Special Protocol Needs: ☐ 3D reformat

Contrast: ☐ Without ☐ With & Without ☐ At Radiologist Discretion

☐ **US** _____

■ **ROUTINE** ☐ **STAT** ☐ **READ & CALL: #**_____ ☐ **HOLD & CALL: #**_____

✶ **Diagnosis/Reason for Exam** Sprain & Strain **ICD-10 (if known)** _____

Encounter Type: ■ Initial ☐ Follow-up Status: ■ Acute ☐ Chronic

Severity _____ Concurrent Conditions _____

Previous Exams Relating to Study Requested? ☐ Yes ■ No Location Where Study Done _____

Provider Name (required/please print) Dr. Bethany Wallace, DO **Scheduler** Diana

✶ **Provider Signature** Sll Attached RX **Date** 03/24/2023

APPOINTMENT INFORMATION

☐ Pre-Auth Assistance ■ Call Patient to Schedule an Appointment ☐ Appointment Notification

Appointment Date _____ Appointment Time _____

Fax To ☐ **Aurora 303-343-3036** ☐ **Denver 303-568-9331** ■ **Thornton 303-630-0405**

07/2020

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Appointment Date _____ Appointment Time _____

Fax To ☐ **Aurora 303-343-3036** ☐ **Denver 303-568-9331** ■ **Thornton 303-630-0405**

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: **DISCHARGED** ☐

1. Concussion
2. C-T-L Strain
3. b/lat - shoulder strain
4. Rt leg pain
5. HA -
6. Anxiety

RECORDS REQUESTED:

☐ St. Anthony's Central ☐ Good Samaritan Medical Center ☐ Denver Health
☐ University Hospital ☐ North Suburban Medical Center ☐ St. Anthony North
☐ Swedish Medical Center ☐ Littleton Adventist Hospital ☐ Kaiser Permanente
☐ Sky Ridge Medical Center ☐ Lutheran Medical Center ☐ St. Joseph's Hospital
☐ Medical Center of Aurora ☐ Rose Medical Center ☐ Porter Adventist Hospital
☐ Children's Hospital ☐ Specialist: _____ ☐ PCP: _____
☐ Other: _____

REFERRAL FOR ADDITIONAL SERVICES (IN OFFICE):

☒ Physical Therapy: Evaluate and Treat
☐ PT-Vestibular
☒ Acupuncture: Evaluate and Treat
☒ Psychology ☒ Driving Anxiety ☐ Biofeedback ☐ TBI
☐ Neuro Optometrist
☐ Podiatrist
☐ BrainCheck 1 ☐ 2 ☐ 3 ☐
☐ BrainCheck Anxiety/Depression 1 ☐ 2 ☐
☐ BrainCheck Vision 1 ☐ 2 ☐

☒ Chiropractic: Evaluate and Treat
☒ Massage Therapy
☐ Neuropsych Eval ☐ Cognitive Screening
☐ Occulogica - EyeBox
☐ Consult for Delayed Healing ☐ Assess for Trigger Point
☐ Regenerative Medicine - PRP ☐ Knee ☐ Shoulder
☐ DO/MD Medication Eval
☐ Other: _____

RESTRICTIONS OR SPECIAL INSTRUCTIONS:

_____

_____

REFERRAL FOR ADDITIONAL SERVICES (OUTSIDE OFFICE):

☐ Spine Surgeon
☐ Pain Specialist Consultation
☐ TMJ Specialist
☐ General Surgeon
☐ Podiatrist Surgeon
☐ Orthopedic Consultation for: _____
☐ Neurologist

☐ Injection Specialist
☐ Dentist
☐ Hand Specialist
☐ Other: _____

REFERRAL FOR DIAGNOSTIC STUDIES: open/bore

☒ MRI/Type: Lumbar spine / Cervical spine ☐ 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.

WALLACE (PROVIDER)

3-10-23 (DATE)