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Diplomate-American Academy of Physical Medicine and Rehabilitation
Pain Medicine Subspecialty Board Certification

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REQUEST CONSULTATION AND RECOMMENDATIONS FOR:

PATIENT: _____ DATE: _____

PATIENT PHONE NUMBER: _____

INSURANCE: _____

PROBLEM:

- Low Back Pain Arm Pain Other _____
- Leg Pain Extremity Numb/Tingle Chronic Pain Med Mngmt.

STUDY REQUESTED: (EMG/Nerve Conduction Studies)

- Carpal Tunnel Screen Left Right Bilateral
- Cervical Radiculopathy Left Right Bilateral
- Lumbar Radiculopathy Left Right Bilateral
- Other _____

PROCEDURE REQUESTED:

- Spine Injections (epidurals, facet injections, etc.) Spinal cord stimulator Suboxone
- Sacroiliac joint injections Ketamine

REFERRING PHYSICIAN (Please Print): _____

SIGNATURE OF REFERRING PHYSICIAN: _____

PHONE: _____ FAX: _____

Thank you. Please fax to (918) 728-8019.

- PLEASE INCLUDE:
- Front/Back of Insurance Card Last Two Office Notes
 - Current Medication List Imaging Reports

Visit us at okspinepain.com.