

OUR MISSION:

TLASO - To Love and Serve Others



TARPON ORTHOPEDICS

Under the direction of

Lewis Frazier, Jr., MD

Comprehensive Physical Medicine, Rehabilitation & Pain Management

Lewis Frazier, Jr., M.D.

Daniel W. Kim, M.D.

Daniel Sunwoo, M.D.

Date: ____/____/____

Patient's Name: _____

Diagnosis: _____

Please attach patient's demographics and insurance card if applicable.

_____ Arthrography
(wrist, elbow, shoulder, hip, knee, ankle)

_____ Carpal Tunnel Injection

_____ Consult & Treat (Neck - Back - Other _____)

_____ Discogram
(cervical, thoracic, lumbar)

_____ Electrodiagnostic Studies

_____ Epidural Blood Patch

_____ Epidural Steroid Injection
(cervical, thoracic, lumbar, sacral)

_____ Facet Joint Injection
(cervical, thoracic, lumbar, sacral)

_____ Medial Branch Blocks
(cervical, thoracic, lumbar)

_____ Myelogram
(cervical, thoracic, lumbar, sacral)

_____ Peripheral Joint Injection
(small, medium, large)

_____ Radio Frequency Ablation
(cervical, thoracic, lumbar, sacral)

_____ Sacroiliac Joint Injection

_____ Selective Nerve Blocks
(cervical, thoracic, lumbar, sacral,
peripheral nerve branch)

_____ Spinal Cord Stimulator

_____ Spine Hardware Injection Blocks

_____ Tendon Sheath/Ligament Injection

_____ Transforaminal Epidural Steroid Injection
(cervical, thoracic, lumbar, sacral)

_____ 2nd opinion

_____ Other

Referring Physician Signature _____

Clinical Staff Name _____ **Phone** _____

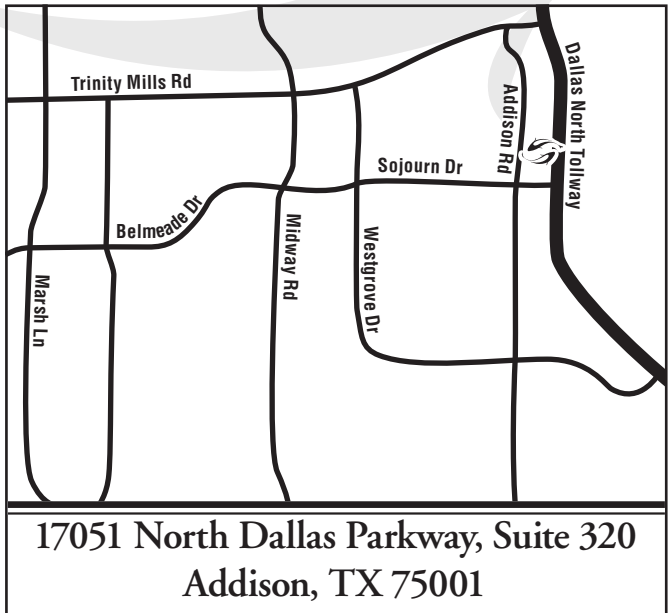
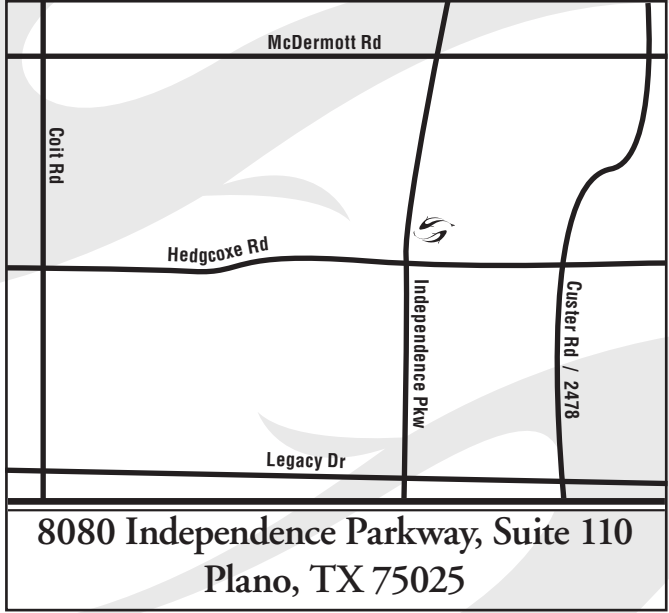
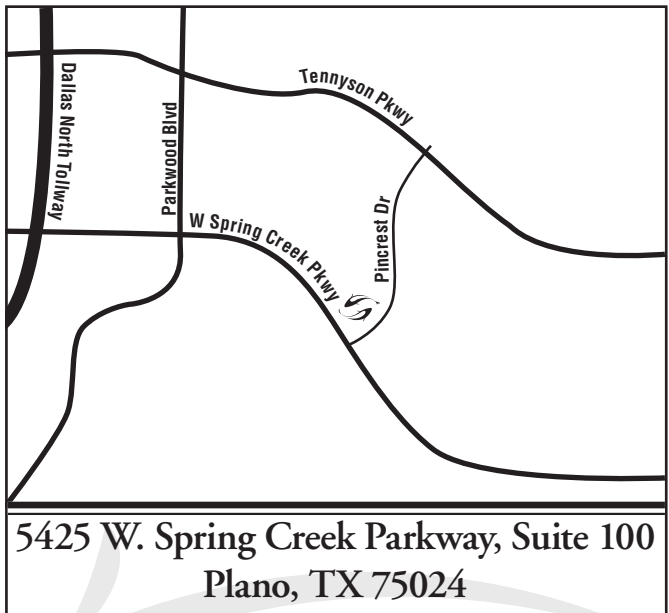
Treating Physician Name _____

5425 W. Spring Creek Parkway, Suite 100
Plano, TX 75024

8080 Independence Parkway, Suite 110
Plano, TX 75025

17051 North Dallas Parkway, Suite 320
Addison, TX 75001

Appointments (972) 596-1059 • Fax (972) 612-5410



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TARPON ORTHOPEDICS

Orthopedic Services

Chris Miller, MD

Date: ____/____/____

Patient's Name: _____

Diagnosis: _____

Please attach patient's demographics and insurance card if applicable.

___ Consult & Treat

___ 2nd opinion

___ Surgical Consult

Diagnosis: _____

Shoulder

Arm

Elbow

Wrist

Hand

Hip

Leg

Knee

Ankle

Foot

(Circle One)

MRI

CT

X RAYS

Please circle if patient has already had any of the above already done.
TARPON has in office xray facilities.

Referring Physician Signature _____

Clinical Staff Name _____ Phone _____

Treating Physician Name _____

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