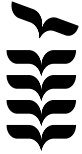

Freedom Spine & Pain Center

REFERRAL DATE: ____________________

PATIENT

Name: ____ DOB: ____________________

Chief Complaint/Diagnosis: ____

Reason for Referral: ____

ORDERING PHYSICIAN

Printed Name: ____

Phone Number: ____ Fax Number: ____________

We appreciate the opportunity to care for your patient. The patient will be contacted by our office within 10 business days. We accept most HMO, PPO, Medicare, Medicare Replacement Plans, and Attorney/LOP Cases. Patients can call 210.920.8945 to schedule an appointment.

Please include the following with your referral:

- *Patient demographics*
- *Last two office visit notes*
- *Most recent imaging reports (within the last year)*
- *Referral form, if required by insurance*

RAJESH K. SHARMA, MD

☐ **BOERNE, TX** *1580 S Main Street, Suite 101*

☐ **KERRVILLE, TX** *251 Cully Drive, Suite A*

☐ **SAN ANTONIO, TX** *5330 North Loop 1604 West, Suite 102*