Provider Referral for Evaluation for Scrambler Therapy

Patient Name: ___________________________ Patient Phone: ___________________________

Referring Provider: ______________________ NPI #: ___________________________

Provider Address: ___________________________________________________________________

Provider Phone #: ______________________ Provider Fax #: ___________________________

Provider Email: ____________________________________________________________________

Evaluate and Treat For:

☐ G62.0 Drug-Induced Polyneuropathy  ☐ G89.3 Neoplasm Related Acute or Chronic Pain
☐ G89.2 Chronic non-malignant pain, back  ☐ M54.3 Sciatica  ☐ G54.6 Phantom Limb Syndrome
☐ B02.29 (other) and B02.22 (Post-herpetic trigeminal neuralgia)

☐ Post-Thoracotomy Pain (G89.22); Post-Mastectomy Pain (G89.28)  ☐ G54.0 Brachial Plexus Neuropathy
☐ M54 Dorsalgia  ☐ G62.89 (Diabetic Polyneuropathy)  ☐ Other (See Comments)

Other (specify): ___________________________________________________________________

Additional Notes: ___________________________________________________________________

Provider Signature: __________________________________________________________________

Date: ______________________

Please fax this form to 310-825-7642
If you prefer, you can email us at TMSReferrals@mednetucla.edu with questions or completed referral forms. We accept interal referrals through CareConnect, please visit our website at tms.ucla.edu/schedule.php for more details.

Thank you for referring your patient to our service. One of our staff will contact you promptly.