Advanced Pain Centers of Alaska

REFERRAL REQUEST

Sola Olamikan, MD, MBA
Ivy Weakland, PA-C

Date: _____ Patient: _____

SS#: _____ DOB: _____

Phone: _____ Insurance Co: _____

_____ Please evaluate and treat the patient.
_____ Please perform the following injection: _____

_____

_____

_____

Allergic to penicillin: _____ Yes _____ No Blood thinners: _____ Yes _____ No

For "Injection Only" referrals, please forward current H&P, Radiology Report, and Medication / Allergy list. Patient is required to bring actual imaging to their first appointment.

Diagnosis/ Symptoms: _____

_____

_____

_____

_____ Return to me for follow up _____ Follow up by APCA

_____ _____
Referring provider name (print) Referring provider signature

_____ _____
Phone Number Fax Number

1917 Abbott Road, Suite 100; Anchorage AK 99507
(907) 278-2741 telephone • (907) 743-8284 fax

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