PMIR™ MEDICAL CENTER
Pain Management and Injury Relief

REFERRAL FORM

☐ **Alexander P. Hersel, M.D.** ☐ **Bradley Spiegel, M.D.**

☐ **Mahyar Okhovat, M.D.** ☐ **Dr Brandon Nguyen, D.O**

☐ Urgent ☐ Routine Date:_____

New Patient Information

Patient Name: _____ D.O.B: _____

Phone Number: _____ Insurance: _____

Diagnosis:_____

Clinical Information:_____

Requested Procedure (if applicable): _____

REFERRING PROVIDER INFORMATION

Referring Provider Signature:_____

Referring Provider Name (Print):_____

Santa Monica Office
2336 Santa Monica Blvd., #208
Santa Monica, CA 90404
P: 310.917.6800
F: 310.917.6804

Simi Valley Office
3695 Alamo Street, #101
Simi Valley, CA 93063
P: 805.522.2740
F: 805.526.2731

Thousand Oaks Office
425 Haaland Drive, #101
Thousand Oaks, CA 91361
P: 805.557.0096
F: 805.557.7360

Hours: Monday - Friday 9:00am - 5:00pm

PATIENT MUST BRING THIS FORM TO EXAM

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