



Cervical Spine Specialists

Appointment Information

Patient Name: _____

Date of Appointment: _____

Time of Appointment: _____

Location of Appointment:

- Ridgeview Professional Building** *(directions attached)*
560 South Maple Street
Suite #200
Waconia, MN 55387

- Twin Cities Orthopedics - Edina** *(directions attached)*
4010 West 65th Street, 2nd Floor – Latte Pod
Edina, MN 55435

It is your responsibility to do the following prior to your appointment:

- **You must bring previous X-rays, CT Scans, or MRI Studies.** We require actual films (printed films or on a CD) and reports, as a report alone is often insufficient.
- Results of previous testing or treatment, which may include EMG's, Physical Therapy, Etc.
- **Completed Health History Questionnaire.** (attached in this packet)
- We will also need copies of your insurance cards. If you have filed a Workers' Comp claim or No Fault claim, you *must* bring copies of all of your information including your claim number, date of injury, adjuster name, phone number and billing address. This information will also be needed when contacting the preregistration department.
- **Prior to your appointment you must contact our preregistration department.** You will not be seen until you have talked with this department. They can be reached at:

952-512-5603

If you have any questions or concerns regarding your appointment,
Please call our office at **(952) 925-2425**.

Getting to Ridgeview Professional Building

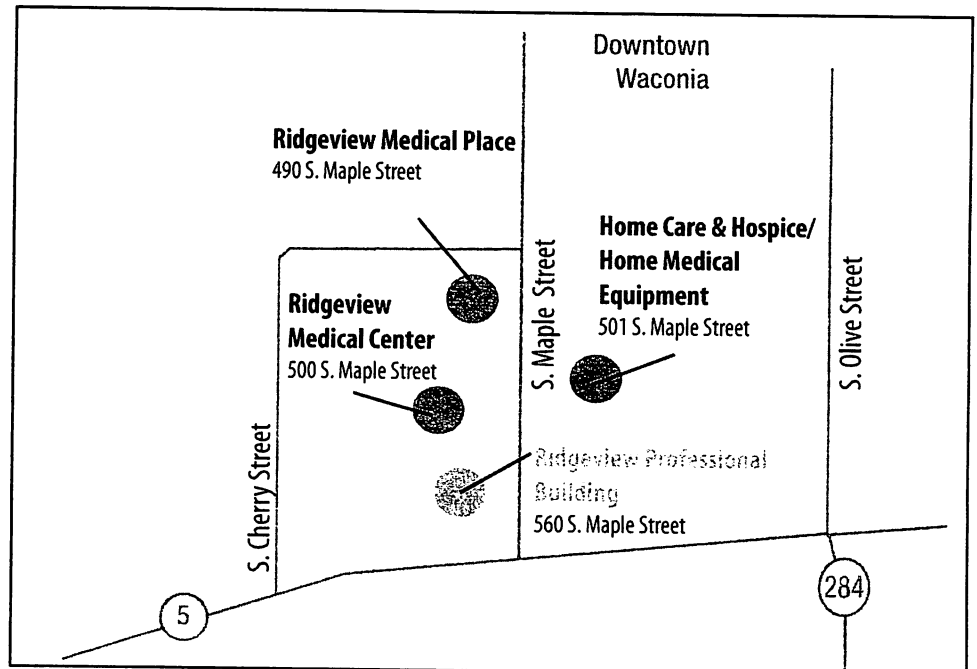
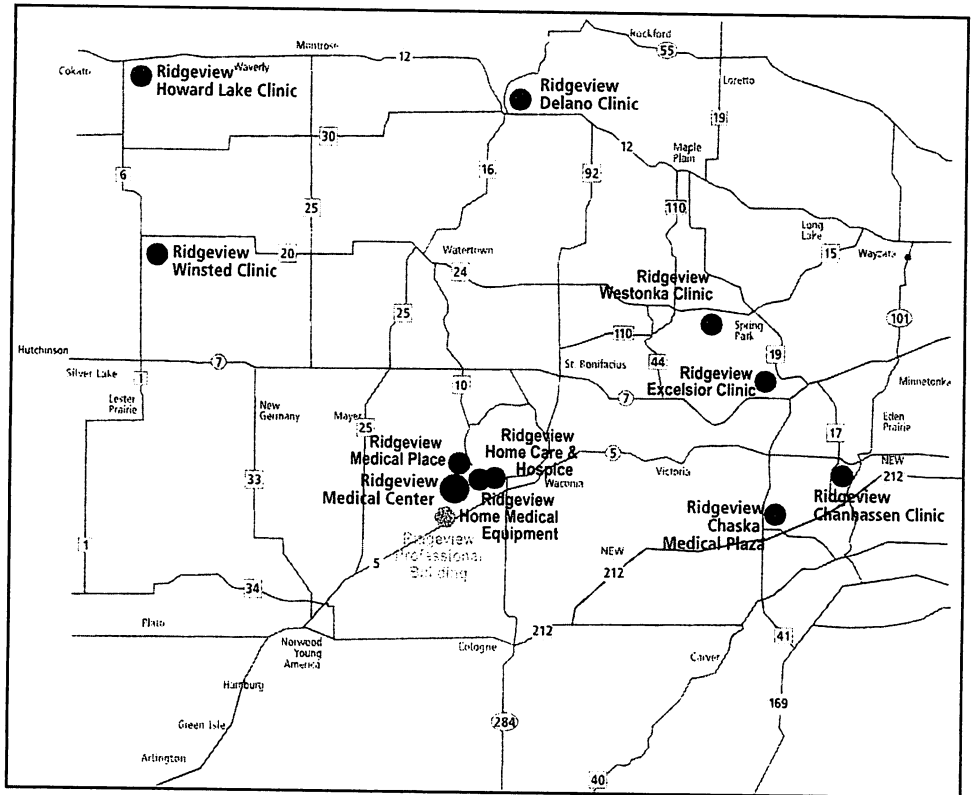
From Minneapolis: Take I-35W south to Hwy. 62 west, and Hwy. 62 west to Hwy. 212/5 west. This will turn into Hwy. 5 west. Continue on Hwy. 5 west through Eden Prairie, Chanhassen and Victoria. Once in Waconia (still on Hwy. 5) look for South Maple Street (1 block after second set of lights on Hwy. 5). Turn right onto South Maple Street. Ridgeview Professional Building is located immediately on the left, at 560 S. Maple Street.

From the North: Take I-494 south to Hwy 5 west. Continue on Hwy. 5 west through Eden Prairie, Chanhassen and Victoria. Once in Waconia (still on Hwy. 5) look for South Maple Street (1 block after second set of lights on Hwy. 5). Turn right on South Maple Street. Ridgeview Professional Building is located immediately on the left, at 560 S. Maple Street.

From the South: Take Hwy. 169 north to Hwy. 41 north. Take Hwy. 41 north to Hwy. 5 west. Take Hwy. 5 west through Victoria. Once in Waconia (still on Hwy. 5) look for South Maple Street (1 block after second set of lights on Hwy 5). Turn right on South Maple Street. Ridgeview Professional Building is located immediately on the left, at 560 S. Maple Street.

From the East: Take I-494 west to Hwy. 5 west. Take Hwy. 5 west through Eden Prairie, Chanhassen and Victoria. Once in Waconia (still on Hwy. 5) look for South Maple Street (1 block after second set of lights on Hwy. 5). Turn right onto South Maple Street. Ridgeview Professional Building is located immediately on the left, at 560 S. Maple Street.

From the West: Take Hwy. 5 east to Waconia. Upon entering Waconia, look for South Maple Street. Turn left onto South Maple Street. Ridgeview Professional Building is located immediately on the left, at 560 S. Maple Street.



Ridgeview Professional Building
560 S. Maple Street • (952) 442-2191





Home » Twin Cities Orthopedics-Edina » Location & Parking Information

Location & Parking Information

Parking: Parking is free for patients, but not for the general public. please ask the receptionist to validate your ticket.

If you are going to physical therapy or getting an MRI, please park on level one.

If you have a physician consultation, please park on level two.

If you are going to the same day surgery center, please park on level three.

Address: 4010 West 65th Street Edina, MN 55435



[View Larger Map](#)

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Directions

EDINA OFFICE – 4010 West 65th Street, Edina, MN 55435

FROM ST. PAUL: Take 1-94 West to South 35W. Take 35W to West Crosstown Highway 62. Go West, exiting on France Avenue. Turn left at stoplight. Turn right on West 65th Street. Parking ramp will be on the right hand side connected to our building.

FROM THE WEST: Take Crosstown Highway 62 East, exiting on Valleyview Road. Go straight through the stoplight. Parking ramp will be on the left connected to our building.

FROM THE SOUTH: Take 35W North to Crosstown Highway 62 West. Go West, exiting on France Avenue. Turn left at stoplight. Turn right on West 65th Street. Parking ramp will be on the right hand side connected to our building.

FROM THE NORTH: Take 35W South to Crosstown Highway 62 West. Go West, exiting on France Avenue. Turn left at stoplight. Turn right on West 65th Street. Parking ramp will be on the right hand side connected to our building.

TWIN CITIES ORTHOPEDICS

FINANCIAL POLICY

The following information is provided to you in order to avoid any misunderstandings concerning payments for professional services:

Co-Payments: All co-payments are due at the time of service. Most major credit cards are accepted.

Insurance Benefits, Referrals and Pre-Certifications: Referrals to see TCO physicians and prior authorizations for procedures (such as MRI*, therapy, or surgery) are the patient's responsibility. If a patient does not obtain the appropriate referrals or authorizations and his/her claims are denied, payment will become the patient's responsibility and due upon receipt of a billing statement. It is patient responsibility to understand his or her insurance benefits and out-of-pocket expenses (including but not limited to non-physician services such as therapy or supplies).

**Some health plans require a reference number for MRIs. TCO will assist in obtaining this reference number. (A reference number is different than an authorization number.)*

Insurance Claims: As a courtesy, TCO files claims for benefits with all insurance companies with claims offices within the United States or its territories. Patient coinsurance, deductibles, or remaining patient responsibility not to exceed the insurance allowable is due upon receipt of a TCO billing statement. Contact the Billing Customer Service staff at 952-512-5625 with any questions.

Uninsured: Patients without insurance are required to pay a portion of charges before services are rendered: \$150 at initial office visit or \$400 at initial fracture care. Monthly payments are not possible for elective surgery charges or MRIs; these services require 100% of payment prior to the service being rendered. If the patient does not bring in required payment at the time of service, the patient may be rescheduled to another day when payment can be made. A prompt pay discount of 20% will be offered for payment in full, if received within 10 days of receiving the first statement. The discount **does not** apply to coinsurance, deductible or patient responsibility amounts discounted by a third party payor.

Uncompensated Care Program: TCO does offer an uncompensated care/financial hardship program. Please contact the TCO Billing Customer Service Department (952-512-5625) to review this program.

Finance Charges: Finance charges may be imposed on accounts beginning 60 days from the date of the initial billing statement. At present the interest rate is 6% per year.

Past Due Balances: Any balance over 90 days old following the initial notice may be placed with a collection agency and/or Credit Bureau. Prior to initiating additional treatment for a new problem, all balances must be paid in full to either TCO or its collection agency.

TCO firmly believes in quality doctor-patient relationships. This is based upon good understanding and communication. The staff of TCO makes every effort to clarify any misunderstanding you have concerning your balance. If you have questions concerning our policy or need assistance, please contact us at 952-512-5625.

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy and/or have been made aware of TCO's Privacy Practices that are posted in the clinic reception area. I understand that I may contact TCO at any time to obtain a current copy of the Notice of Privacy Practices.

Patient Signature: _____ Date: _____



Cervical Spine Specialists

PATIENT INFORMATION RELEASE

Name _____ Birth date _____

Address _____

Requestor to whom information should be sent:

- Referral physicians
- Primary care physician _____
- Other (please specify) _____

Information should include:

- All records
- Hospital Notes (to include operative notes, x-ray, pathology, discharge summaries, lab tests)
- Typed radiology reports
- Primary clinic notes
- X-ray films or copies
- Other _____

From (month/day/year): _____ To (month/day/year): _____

List any information you do not want released:

I give permission to CERVICAL SPINE SPECIALISTS and TWIN CITIES ORTHOPEDICS to release Medical Record Information to the Requestor concerning the Medical Condition or Injury described above which was diagnosed/treated during the stated time period above. The information released may include, but not be limited to that which involves treatment for alcohol and drug abuse; will be limited by any INFORMATION RESTRICTIONS outlined above; and may only be used for the purpose stated above. I understand that this release will take effect on the date signed and will be good for 1 year.

Signature _____ Date _____

Mailing Address 7261 Ohms Lane Edina, MN 55439
Waconia Clinic 560 South Maple Street, Suite #200 Waconia, MN 55387
Edina Office 4010 West 65th Street Edina, MN 55435
Phone: 952-925-2425 **Fax:** 952-925-2038



Cervical Spine Specialists

Physicians:

Michael Smith, MD

PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____

Chief Complaint

Reason for today's visit? _____

Current problem is the result of a(n): **check all that apply**

Car Accident Work Accident Accident Other _____

Referral Data

Name of Referring Physician: _____

Address: _____

Name of Primary Physician: _____

Address: _____

Past History

Please list any prior illnesses and / or injuries: _____

Surgeries / Hospitalizations	Year	Complications

Have you ever had problems with anesthesia? Yes No

Current Medication(s) including herbal/homeopathic remedies	Dose	Frequency

ALLERIGIES TO MEDICATIONS (list below):	<input type="checkbox"/> NKDA (if none)

Patient Name: _____ Date of Birth: _____

Have you had a MRI? Yes No Have you had a CT scan? Yes No
Are you Claustrophobic? Yes No

MRI or CT Scan History	Date	Place	Area Scanned

Family Medical History

Family Member	Alive	Deceased	Age	Health Status or Cause of Death
Father	A	D		
Mother	A	D		
Sister / Brother	A	D		
Sister / Brother	A	D		
Sister / Brother	A	D		
Sister / Brother	A	D		

Social History

Occupation: _____

Marital Status: Single Married Divorced Widowed

Do you have children? Yes No How many? _____

Do you live alone? Yes No Who lives with you? _____

Do you smoke? Yes, I've smoked _____ packs of cigarettes per day for _____ years.

Yes, I smoke cigars or a pipe _____ times per week.

No, I quit _____ years ago. At that time I was smoking _____ packs per day for _____ years.

No, I have never smoked.

Do you drink alcohol? Yes No, never (or rarely) No, but I used to

If yes, how many days per week do you drink? _____ How many drinks per day? _____

Have you ever been evaluated or treated for substance dependence? If yes, please list treatment and date:

Are you at risk for AIDS (e.g. sexual practices, IV drug use, previous blood transfusion)?

No Yes, please explain: _____

Patient Name: _____ Date of Birth: _____

Review of Systems

Constitutional

Height: _____

Weight: _____

Blood Pressure: _____

Do you currently, or have you had, problems with:

	<i>Circle One</i>	
Fever	Yes	No
Weight Loss	Yes	No
Excessive fatigue	Yes	No
Night Sweats	Yes	No
If, yes, how often? _____		

Eyes

Wear Glasses – Date of Last Exam: _____	Yes	No
Infections	Yes	No
Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No

Ear, Nose, Throat and Mouth

Wear Hearing Aids – Date of Last Exam: _____	Yes	No
Hearing Loss	Yes	No
Ear Pain	Yes	No
Ear Infections	Yes	No
Ring in Ears <i>Circle:</i> Left Right Both	Yes	No
Balance Disturbance (e.g., Vertigo, Spinning)	Yes	No
Nosebleeds	Yes	No
Nasal Congestion	Yes	No
Nasal Drainage – Amount _____ Color _____	Yes	No
Inability to Smell	Yes	No
Sinus Problems	Yes	No
Sinus Headaches	Yes	No
Sore Throats	Yes	No
Mouth Sores	Yes	No

Cardiovascular

Chest Pain or Angina – Date of Last EKG: _____	Yes	No
High Blood Pressure	Yes	No
Irregular Pulse	Yes	No
Heart Murmur	Yes	No
High Cholesterol	Yes	No
Swelling in Feet or Hands	Yes	No
Leg Pain While Walking	Yes	No
Do you have a pacemaker?	Yes	No

Patient Name: _____ Date of Birth: _____

Respiratory

Asthma	Yes	No
Chronic Cough	Yes	No
Emphysema	Yes	No
Shortness of Breath	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Lung Cancer	Yes	No
Bloody Sputum	Yes	No
Date of Last Chest X-ray: _____		

Gastrointestinal

Indigestion or Pain with Eating	Yes	No
Nausea	Yes	No
Vomiting	Yes	No
Blood in Your Vomit	Yes	No
Liver Disease	Yes	No
Jaundice	Yes	No
Abdominal Pain	Yes	No
Change in Your Bowel Habits	Yes	No
Ulcers or Gastritis	Yes	No
Colon Cancer	Yes	No

Genitourinary

Urinary Tract Infections	Yes	No
Painful Urination	Yes	No
Blood in Your Urine	Yes	No
Difficulty Starting or Stopping Stream	Yes	No
Incontinence	Yes	No
Kidney Stones	Yes	No
Prostate Cancer (Males)	Yes	No
Endometriosis (Females)	Yes	No
Uterine or Cervical Cancer (Females)	Yes	No

Musculoskeletal

Broken Bone – List: _____	Yes	No
Arm or Leg Weakness	Yes	No
Back Pain	Yes	No
Arm or Leg Pain	Yes	No
Joint Pain or Swelling	Yes	No
Arthritis	Yes	No
Do you have implants (i.e. artificial Knee, Hip) _____	Yes	No

Integumentary

Skin Disease	Yes	No
Skin Cancer	Yes	No
Breast Pain, Tenderness or Swelling (Female)	Yes	No
Nipple Discharge (Females)	Yes	No
Date and Result of Last Mammogram (Females) _____		

Patient Name: _____ Date of Birth: _____

Neurological

Fainting Spells or "Blacking Out"	Yes	No
Seizures	Yes	No
Problems with Your Memory	Yes	No
Disorientation	Yes	No
Difficulty with Your Speech	Yes	No
Inability to Concentrate	Yes	No
Double or Blurred Vision	Yes	No
Face Weakness	Yes	No
Coordination in Arm and / or Legs	Yes	No

Psychiatric

Anxiety	Yes	No
Depression	Yes	No
Other Psychiatric Disorder / Treatment: _____	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid Disease	Yes	No
Increased Appetite	Yes	No
Excessive Thirst or Urination	Yes	No
Hormone Problems	Yes	No

Hematologic / Lymphatic

Anemia	Yes	No
Hemophilia	Yes	No
Bleeding Tendencies	Yes	No
Persistent Swollen Glands or Lymph Nodes	Yes	No
Blood Transfusion		
If yes, when? _____		

Allergic / Immunologic

Food Allergies	Yes	No
Inhalant (nasal) Allergies	Yes	No
Immunologic Disorders	Yes	No

The above information is accurate to the best of my knowledge.

Patient Signature _____
Date

I have reviewed the above information with the patient.

Physician Name (Printed) & Signature _____
Date

I have re-reviewed the above information with the patient

Physician Name (Printed) & Signature _____
Date

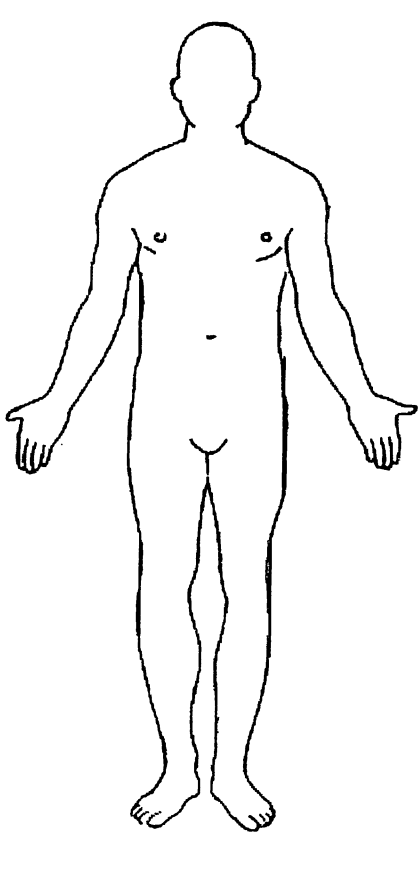
Physician Name (Printed) & Signature _____
Date



PAIN DIAGRAM

NAME: _____ DATE: _____

Mark these drawings according to where you hurt (if the back of your neck hurts, mark the drawing on the back of the neck, etc.). If you feel any of the following symptoms, please indicate where you feel them by placing the marks shown here on the diagram. Include all affected areas.



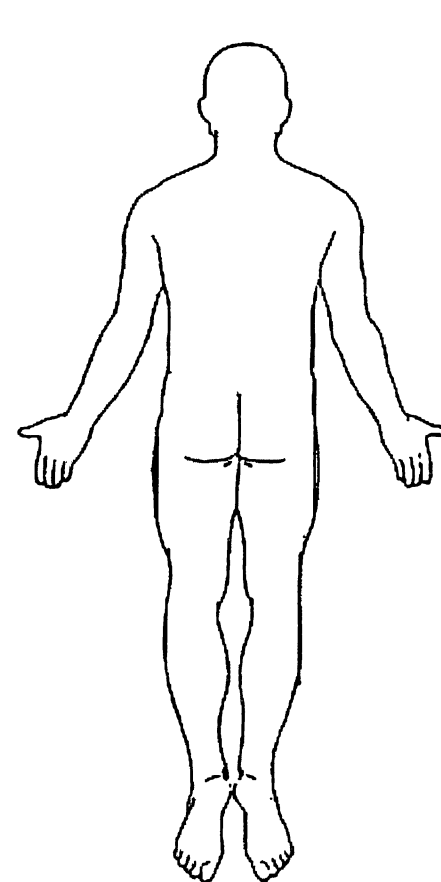
Numbness
|| || rr ||

Pins and Needles
0 0 0 0 0

Burning
x x x x x

Stabbing
//////

Ache
^ ^ ^ ^ ^



Please mark with an X on the body form where the pain is worst now.

Please circle the appropriate number below showing how bad your pain is now:

No pain 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Cervical Spine Pre-Op Form - Twin Cities Orthopedics

STICKER FIELD

If there is not any sticker available please write the required data below:

Patient Last Name / First Name:

Chart Number:

Date of Birth:

Date of Clinic Visit:

Date of Surgery: (MM/DD/YYYY)

		/		/			
--	--	---	--	---	--	--	--

What's patient's height?

<input style="width: 100%; height: 100%;" type="text"/>	Feet	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	Inches
---	------	---	---	--------

What's patient's weight?

<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	<input style="width: 100%; height: 100%;" type="text"/>	Pounds
---	---	---	--------

Marking Instructions: Please FILL in the appropriate boxes or circles

Printing Instructions: Please Print in ALL CAPITAL letters & keep all letters within the box

Please select your surgeon from the list below:

- Jeffrey C Dick, MD
- David C Holte, MD
- John E Sherman, MD
- Michael D Smith, MD



Race/Ethnicity (optional question): Please select one

- White
- Black or African-American
- Hispanic or Latino
- Asian
- American Indian and Alaska Native
- Native Hawaiian and Other Pacific Islander
- Other



Patient Demographics Information

Education Level: Please select one

- No schooling completed
- Less than 12th grade
- 12th grade, NO DIPLOMA
- High school DIPLOMA or the equivalent (for example: GED)
- Some college credit, but less than 1 year
- Associate degree (for example: AA, AS)
- Bachelor's degree (for example: BA, AB, BS)
- Master's degree (for example: MA, MS, MEng, MEd, MSW, MBA)
- Professional degree (for example: MD, DDS, DVM, LLB, JD)
- Doctorate degree (for example: PhD, EdD)

Do you currently smoke cigarettes or use any other tobacco products ? (Mark one response.)

- Yes
- No, I quit smoking or using any other tobacco products less than 6 months ago.
- No, I quit smoking or using any other tobacco products more than 6 months ago.
- No, I have never smoked or used any other tobacco products . (If select this choice; GO TO NEXT PAGE)

How many years have you been smoking/using or did you smoke/use cigarettes or any other tobacco products?

Years

On average, how many packs of cigarettes/tobacco products do you or did you smoke each day?

- ¼ pack per day or less (5 cigarettes or less)
- ½ pack per day
- 1 pack per day
- 1 ½ packs per day
- 2 packs or more per day



Surgery History & Comorbidities

Have you ever had any "neck related spine surgery" previously?

- No. I have never had "neck related spine surgery" previously
- I had 1 surgery
- I had 2 surgeries
- I had 3 or more surgeries

Comorbidities:

YES **NO**

Do you have heart disease?

If you have heart disease, does it limit your activities?

Do you have lung disease?

If you have lung disease, does it limit your activities?

Do you have diabetes?

Do you have fibromyalgia?

Please continue to the next page



Under each heading, please fill ONE circle that best describes your health TODAY.

Mobility

- I have no problems walking
- I have slight problems walking
- I have moderate problems walking
- I have severe problems walking
- I am unable to walk



Self-Care

- I have no problems washing or dressing myself
- I have slight problems washing or dressing myself
- I have moderate problems washing or dressing myself
- I have severe problems washing or dressing myself
- I am unable to wash or dress myself

Usual Activities (e.g. work, study, housework, family or leisure activities)

- I have no problems doing my usual activities
- I have slight problems doing my usual activities
- I have moderate problems doing my usual activities
- I have severe problems doing my usual activities
- I am unable to do my usual activities

Pain/Discomfort

- I have no pain or discomfort
- I have slight pain or discomfort
- I have moderate pain or discomfort
- I have severe pain or discomfort
- I have extreme pain or discomfort

Anxiety/Depression

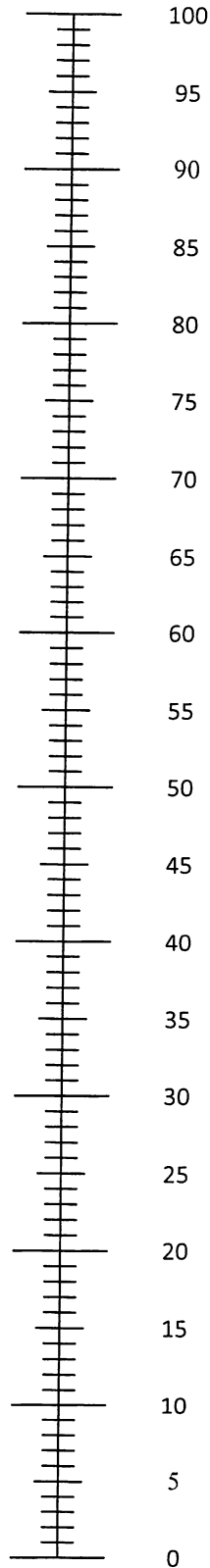
- I am not anxious or depressed
- I am slightly anxious or depressed
- I am moderately anxious or depressed
- I am severely anxious or depressed
- I am extremely anxious or depressed



EQ-5D-5L™ (continues)

- We would like to know how good or bad your health is TODAY.
- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
0 means the worst health you can imagine.
- Select a number on the scale to indicate how your health is TODAY.
- Now, please write the number you selected on the scale in the box ABOVE.

The best health
you can imagine



The worst health
you can imagine

Your Health Today (0-100)

--	--	--

Please enter your health state score
above



NECK DISABILITY INDEX

This questionnaire is designed to give us information about how your NECK (or ARM) trouble affects your ability to manage your daily life. Please answer every section and mark in each section only the ONE box that applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just mark the box that most closely describes your problem.



1. Pain intensity

- I have no neck pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

2. Personal care

- I can look after myself normally without causing extra neck pain.
- I can look after myself normally, but it causes extra neck pain.
- It is painful to take care of myself, and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self-care.
- I do not get dressed. I wash with difficulty and stay in bed.

3. Lifting

- I can lift heavy weights without causing extra neck pain.
- I can lift heavy weights, but it gives me extra neck pain.
- Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned
- I can lift only very light weights.
- I cannot lift or carry anything at all.



4. Work

- I can do as much work as I want.
- I can only do my usual work, but no more.
- I can do most of my usual work, but no more.
- I can't do my usual work.
- I can hardly do any work at all.
- I can't do any work at all.



5. Headaches

- I have no headaches at all.
- I have slight headaches that come infrequently.
- I have moderate headaches that come infrequently.
- I have moderate headaches that come frequently.
- I have severe headaches that come frequently.
- I have headaches almost all the time.

6. Concentration

- I can concentrate fully without difficulty.
- I can concentrate fully with slight difficulty.
- I have a fair degree of difficulty concentrating.
- I have a lot of difficulty concentrating.
- I have a great deal of difficulty concentrating.
- I can't concentrate at all.

7. Sleeping

- I have no trouble sleeping.
- My sleep is slightly disturbed for less than 1 hour.
- My sleep is mildly disturbed for up to 1-2 hours.
- My sleep is moderately disturbed for up to 2-3 hours.
- My sleep is greatly disturbed for up to 3-5 hours.
- My sleep is completely disturbed for up to 5-7 hours.

8. Driving

- I can drive my car without neck pain.
- I can drive my car with only slight neck pain.
- I can drive as long as I want with moderate neck pain.
- I can't drive as long as I want because of moderate neck pain.
- I can hardly drive at all because of severe neck pain.
- I can't drive my car at all because of neck pain.



9. Reading

- I can read as much as I want with no neck pain.
- I can read as much as I want with slight neck pain.
- I can read as much as I want with moderate neck pain.
- I can't read as much as I want because of moderate neck pain.
- I can't read as much as I want because of severe neck pain.
- I can't read at all.

10. Recreation

- I have no neck pain during all recreational activities.
- I have some neck pain with all recreational activities.
- I have some neck pain with a few recreational activities.
- I have neck pain with most recreational activities.
- I can hardly do recreational activities due to neck pain.
- I can't do any recreational activities due to neck pain.

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Please continue to the next and last questionnaire



VISUAL ANALOG PAIN SCALE – NECK PAIN

Indicate the severity of your pain today by marking X in one circle that most applies to you.
See the example below:



Migraine Pain:

0 No Pain 10 Worst Possible Pain

Neck Pain Questionnaire

NECK PAIN:

0 No Pain 10 Worst Possible Pain

RIGHT ARM PAIN:

0 No Pain 10 Worst Possible Pain

LEFT ARM PAIN:

0 No Pain 10 Worst Possible Pain

HIP PAIN: If you had donor bone removed from iliac crest, describe your hip pain.

0 No Pain 10 Worst Possible Pain





Medication Refill Policy

In order to best serve you, Cervical Spine Specialists follows a refill policy for prescriptions. In the event that medication is prescribed, your situation will be individually addressed. However, similar guidelines will be followed for all prescriptions. Please notify your doctor of all medications that you currently take and of any other doctors who provide medication for you.

- ◆ Medication is usually prescribed in conjunction with the recommendation for surgery. Occasionally, non-surgical patients receive prescription medication as part of their treatment; however, this is not our standard procedure.
- ◆ **Prescriptions may be refilled Monday through Thursday during business hours (8:30 AM to 4:00 PM).**
- ◆ **Prescriptions are not refilled on evenings or weekends.**
- ◆ **Please allow 48 hours for refill requests to be processed.**
- ◆ You, your spouse, or your pharmacy may request refills by calling (952) 925-2425. When leaving a message, please provide the following information:
 - ◆ Your name
 - ◆ Your phone number
 - ◆ The type of medication you are requesting
 - ◆ The amount of medication you are requesting
 - ◆ The last time your medication was refilled
 - ◆ The name and phone number of the pharmacy you will be using for refills
 - ◆ **All of the above information is required to process your request as soon as possible**
- ◆ A nurse may contact you if there are any questions about your request.
- ◆ Post-operative patients will receive specific information about refills during the hospital checkout process.
- ◆ Pharmacies require a written prescription for Class II drugs such as OxyContin, Percodan, and Percocet and these drugs cannot be called in. Class II drugs are not usually needed after cervical spine surgery.

If you have any questions about our refill policy, please call our office.

Mailing Address 7261 Ohms Lane Edina, MN 55439
Waconia Clinic 560 South Maple Street, Suite #200 Waconia, MN 55387
Edina Office 4010 West 65th Street, Edina, MN 55435