Print Form

Progressive Rehabilitation Associates
503-292-0783
800-320-0681
fax 503-292-5208
1815 SW Marlow, Suite 110 • Portland, Oregon 97225

Referral Form

Patient:

First Name _____ Middle Init _____ Last Name _____

Address _____ City, State _____ Zip _____

(_____)_____ (_____)_____
Home Phone Alternate Phone

Date of Birth _____ Gender _____

Insurance Information:

Diagnosis (ICD9) / Accepted Conditions: _____

_____

Insurance Company: _____

Insurance Phone: (_____) _____

Claim/ID #: _____

Please select appropriate box (required to test to tolerance)

Important: Please choose 1

☐ **No Restrictions** for Functional Assessment

☐ **Restrictions** as follows: _____

Work Comp.	Commercial Insurance	Pain Management Programs
☐	☐	**Pain Management Program Evaluation:** Interdisciplinary assessment of chronic pain patient (MD, Psych., PT – Work Comp. also includes Vocational & OT)
☐	☐	**Pre-Surgical Pain Management Evaluation:** Interdisciplinary assessment of patients being considered for SCS, spinal fusion or disc replacement (MD, Psych., PT – Work Comp. also includes Vocational & OT)
☐	☐	**Pre-surgical Psychological Evaluation:** Assess psychological suitability for SCS, pump, lumbar fusion, or disc replacement

Work Comp. Only	Work Hardening/Conditioning
☐	**Disability Prevention Evaluation:** Interdisciplinary evaluation, typically for worker's comp claim that is not progressing (MD, Psych, Vocational Eval., two hour PCE)
☐	**Work Hardening/Conditioning Evaluation:** Identifies suitability for a strengthening program designed to return worker to the **job-at-injury** or **full-time suitable employment**. Includes PT, two hour PCE, one hour vocational evaluation. ☐ **include** Psych

Work Comp.	Commercial Insurance	Brain Injury Rehab Center (BIRC)
☐	☐	**Brain Injury Rehab Center Evaluation:** (Danielle Erb MD, PT, OT, SLP, Psych)
☐	☐	**Day Treatment per recommendations from BIRC evaluation**
☐	☐	**Neuropsychological Evaluation**

Work Comp.	Commercial Insurance	Outpatient Services
☐	☐	**Vestibular Evaluation**
☐	☐	**Low Vision Evaluation**
☐	☐	**Biofeedback Evaluation**
☐	☐	**PT Evaluation**
☐	☐	**OT Evaluation**
☐	☐	**Speech/Language Pathology Evaluation**
☐	☐	**Psychological Evaluation**

Signature: _____

Date: ____/____/_____

Physician Name: _____

Physician Phone: (_____) _____

Physician Fax: (____) _____

How did you first hear about our clinic? Please Circle
Inservice Colleague Conference Internet search Mailing
Other _____

Please fax completed form to 503-595-7795