pra Progressive Rehabilitation Associates

503-292-0765
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 (ICD - 10) / Accepted Conditions:
_____

_____

Insurance Company: _____

Insurance Phone: (_____) _____

Claim/ID #:_____

Important: Please check 1

Please select appropriate box (required for Physical Test to Tolerance)

☐ **No Restrictions** for Functional Assessment

☐ **Restrictions** as follows:_____

Work Comp	Comm. Insurance	Medicaid	Pain Rehabilitation Programs
☐	☐		**Pain Management Program Evaluation:** Interdisciplinary assessment of chronic pain patient (MD, Psych., PT – Work Comp may 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 may also includes Vocational & OT)
☐	☐	☐	**Pre-surgical Psychological Evaluation:** Assess psychological suitability for SCS, pump, lumbar fusion, or disc replacement
	☐	☐	**Pain Rehabilitation Program**: Behavioral Health evaluation & treatment for chronic pain condition
Work Comp. Only			**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/OT, and Program Coordinator evaluation. ☐ **include** Psych
☐			

Work Comp.	Commercial Insurance	Brain Injury Rehab Center (BIRC) Portland Location Only
☐	☐	**Brain Injury Rehab Center Evaluation:** (MD, PT, OT, SLP, Psych) **Treatment per recommendations from BIRC evaluation**
☐	☐	

Work Comp	Comm. Insurance	Medicaid	Outpatient Services
☐	☐	☐	**Physical Therapy** Evaluation & Treatment
☐	☐	☐	**Vestibular** Evaluation & Treatment
☐	☐	☐	**Occupational Therapy** Evaluation & Treatment
☐	☐	☐	**Speech/Language Pathology** Evaluation & Treatment
☐	☐	☐	**Psychology** Evaluation & Treatment
☐	☐	☐	**Biofeedback** Evaluation & Treatment
☐	☐	☐	**Activity Coaching** Evaluation & Treatment

Signature: _____
Date

Physician Name: _____

Physician Phone: (_____) _____

Physician Fax: (____) _____

Revised 11/20/16

Please fax completed form to 503-595-7795