

Referral Form

Patient:

Insurance Information:

First Name Middle Init Last Name

Diagnosis (ICD - 10) / Accepted Conditions:

Address City, State Zip

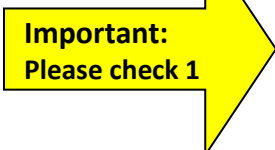
Insurance Company: _____

(_____) (_____) Home Phone Alternate Phone

Insurance Phone: (_____) _____

Date of Birth Gender

Claim/ID #: _____



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

No Restrictions for Functional Assessment

Restrictions as follows: _____

Work Comp	Comm. Insurance	Medicaid	
<input type="checkbox"/>	<input type="checkbox"/>		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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	
Work Comp. Only			
<input type="checkbox"/>			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. <input type="checkbox"/> include Psych

Work Comp.	Commercial Insurance		
<input type="checkbox"/>	<input type="checkbox"/>		Brain Injury Rehab Center (BIRC) <u>Portland Location Only</u> Brain Injury Rehab Center Evaluation: (MD, PT, OT, SLP, Psych) Treatment per recommendations from BIRC evaluation
<input type="checkbox"/>	<input type="checkbox"/>		
Work Comp	Comm. Insurance	Medicaid	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Signature: _____ Date _____

Physician Name: _____

Physician Phone: (_____) _____

Physician Fax: (_____) _____