

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)

No Restrictions for Functional Assessment

Restrictions as follows:

**Important:
Please choose 1**

Work Comp. Insurance	Pain Management Programs
<input type="checkbox"/> <input type="checkbox"/>	Pain Management Program Evaluation: Interdisciplinary assessment of chronic pain patient (MD, Psych., PT – Work Comp. also includes Vocational & OT)
<input type="checkbox"/> <input type="checkbox"/>	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)
<input type="checkbox"/> <input type="checkbox"/>	Pre-surgical Psychological Evaluation: Assess psychological suitability for SCS, pump, lumbar fusion, or disc replacement

Work Comp. Only	Work Hardening/Conditioning
<input type="checkbox"/>	Disability Prevention Evaluation: Interdisciplinary evaluation, typically for worker's comp claim that is not progressing (MD, Psych, Vocational Eval., two hour PCE)
<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, two hour PCE, one hour vocational evaluation. <input type="checkbox"/> include Psych

Work Comp. Insurance	Brain Injury Rehab Center (BIRC)
<input type="checkbox"/> <input type="checkbox"/>	Brain Injury Rehab Center Evaluation: (Danielle Erb MD, PT, OT, SLP, Psych)
<input type="checkbox"/> <input type="checkbox"/>	Day Treatment per recommendations from BIRC evaluation
<input type="checkbox"/> <input type="checkbox"/>	Neuropsychological Evaluation

Work Comp. Insurance	Outpatient Services
<input type="checkbox"/> <input type="checkbox"/>	Vestibular Evaluation
<input type="checkbox"/> <input type="checkbox"/>	Low Vision Evaluation
<input type="checkbox"/> <input type="checkbox"/>	Biofeedback Evaluation
<input type="checkbox"/> <input type="checkbox"/>	PT Evaluation
<input type="checkbox"/> <input type="checkbox"/>	OT Evaluation
<input type="checkbox"/> <input type="checkbox"/>	Speech/Language Pathology Evaluation
<input type="checkbox"/> <input type="checkbox"/>	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