

Referral Form

Patient:

First Name	Middle Initial	Last Name
Address		
City	State	Zip
()	Date of Birth	Gender
Home Phone		

Insurance Information:

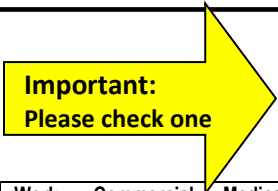
Diagnosis (ICD - 10) / Accepted Conditions: _____

Insurance Company: _____

Insurance Phone: () _____

Claim/ID#: _____

PLEASE SEND MEDICAL CHART NOTES WITH THIS REFERRAL



Work Comp	Commercial 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 include 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 include 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			Work Hardening/Conditioning Evaluation: Identifies suitability for a strengthening program designed to return worker to the <u>job-at-injury</u> or <u>full-time suitable employment</u> . 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	Outpatient Services
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Therapy Evaluation & Treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vestibular Evaluation & Treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Occupational Therapy Evaluation & Treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language Pathology Evaluation & Treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychology Evaluation & Treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Biofeedback Evaluation & Treatment
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Activity Coaching Evaluation & Treatment

Signature: _____ Date: _____

Physician Name: _____

Physician Phone: () _____