PRA Progressive Rehabilitation Associates

1815 SW Marlow Ave, Suite 110 Portland, Oregon 97225 503-292-0765 800-320-0681 FAX: 503-595-7795

Referral Form

Patient:

First Name Middle Initial Last Name

Address

City State Zip

(_____)_____

Home Phone Date of Birth Gender

Insurance Information:

Diagnosis (ICD - 10) / Accepted Conditions:

_____

Insurance Company:_____

Insurance Phone: (_____)_____

Claim/ID#:_____

Important: Please check one

PLEASE SEND MEDICAL CHART NOTES WITH THIS REFERRAL

Work Comp	Commercial Insurance	Medicaid	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
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: (_____) _____

Fax completed form to 503-595-7795