

# PHYSICAL THERAPY REFERRAL

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## PATIENT INFORMATION

Patient Name:	<input type="text"/>	DOB:	<input type="text"/>
Insurance Carrier:	<input type="text"/>	Insurance ID:	<input type="text"/>
Group #:	<input type="text"/>	Plan Name:	<input type="text"/>
Address:	<input type="text"/>		
Patient Contact Info:	<input type="text"/>		

## DIAGNOSIS

Patient Dx:

Surgical?  Yes  No      Surgery Date:

Procedure:

Date of Injury:

ICD-10 Code(s):

1.       2.       3.

Case Type (select one):  Work Comp     No-Fault     PPO / HMO     Medicare / Medicaid

VA / TRICARE, Work Comp, No-Fault & MVA: complete page 2.

## ORDERS

- |   |  |
|---|--|
| <input type="checkbox"/> Eval and Treat                       | <input type="checkbox"/> Therapeutic Exercise              |
| <input type="checkbox"/> Initial Evaluation                   | <input type="checkbox"/> Gait Training                     |
| <input type="checkbox"/> Therapeutic Activity                 | <input type="checkbox"/> Patient Self-Management Education |
| <input type="checkbox"/> Neuromuscular Re-Education / Balance |  |

Other:

Precautions / Contraindications:

## PLAN OF CARE

Referring Physician:	<input type="text"/>		
Office / Clinic Name:	<input type="text"/>		
Office Phone:	<input type="text"/>	Office Fax:	<input type="text"/>
Frequency:	<input type="text"/>	Duration:	<input type="text"/>
MD Signature:	<input type="text"/>	MD NPI:	<input type="text"/>
Date:	<input type="text"/>		

Work Comp, No-Fault, MVA, VA & TRICARE patients: please also complete the AUTHORIZATION block on page 2.

# AUTHORIZATION

Complete the block that matches the patient's coverage, then attach to page 1.

## PATIENT REFERENCE

Patient Name:  DOB:

## WORK COMP / NO-FAULT / MVA

Coverage Type (select one):  Work Comp  No-Fault  Motor Vehicle Accident (MVA)

Insurance Carrier:  Claim #:

Date of Injury / Accident:  Employer (Work Comp):

Authorization / Approval #:  Date of Service Approved:

Auth Start Date:  Auth End Date:

# Visits Authorized:

## NURSE CASE MANAGER

NCM Name:  Phone:

Fax:  Email:

Claim Adjuster:

## VA / TRICARE

Program (select one):  Tricare Prime  Tricare Select  Tricare For Life  VA Community Care

Patient Status (select one):  Active Duty  Retiree  Dependent  Veteran

Sponsor Name:  Sponsor DBN / last 4:

Beneficiary Category:  Branch of Service:

*Do not enter the full Social Security Number. Use the sponsor DBN or last 4 digits only.*

Authorization / Referral #:  Episode of Care #:

Auth Start Date:  Auth End Date:

# Visits Authorized:

## PRIMARY CARE MANAGER (PCM) / REFERRING FACILITY

PCM Name:  PCM NPI:

Facility Name:

Facility Address:

Facility Phone:  Facility Fax:

Authorizing Contact / POC:

Notes: