

Referral Form

Date: _____

SERVICE REQUESTED: PCE (1045M) 1 Day 2 Day Hand/UE PCE (1045M) Baseline/Job Specific/Test to Tolerance Work Conditioning (97001-97004; 97110, 97530, 97537) Work Hardening (1001M, 97545, 97546) Physical Therapy Occupational Therapy (97001-97140) Pre/Job Modification Consult (0389R, 0391R, 0392R) JA (0389 R) Interpreter (9998M) _____

Client's Name: _____

Claim #: _____

Address: _____

P #: _____

DOB: _____

DOI: _____

SSI#: _____

Diagnosis: _____

Dx. Code: _____

JOI: _____

Employer: _____

Return to job of Injury? YES NO

Job Goal: _____

VRC: _____

P/F #: _____

Address: _____

CM/Company: _____ L& I Unit #: _____

Address: _____ P/F #: _____

AP: _____ P/F #: _____

Address: _____

Attorney: _____ P/F #: _____

RN Case Manager: _____ P/F #: _____

Address: _____

Purpose of Referral: _____ Voc. Phase: EI/AWA/Plan./Other: _____

HTN: YES NO Diabetes: YES NO Head Injury: YES NO Substance Abuse: YES NO

Brief Med. Hx/Limitations/Surgery/BP: _____

Referral Signature: _____ P #: _____