INDustrial Health
an Inova | Industrial Rehab Partnership

REFERRAL FORM

NAME:_____ **DOI:**_____

ADDRESS:_____

_____

PHONE:_____ **ALT. PHONE:** _____

DOB:_____ **SSN:**_____ **EMPLOYER:**_____

REFERRING PHYSICIAN:_____

PHONE:_____ **FAX:**_____

DIAGNOSIS:_____ **FOLLOW-UP APPT:**_____

SURGERY: Y / N **DATE OF SURGERY:**_____ **RECORDS REQUESTED:**_____

INSURANCE CARRIER:_____

ADDRESS:_____

_____

PHONE: _____ **CLAIM #**_____

AUTHORIZED: Y / N **DATE AUTHORIZED:** _____ **BY:**_____

CASE MANAGER:_____ **JOB DESCRIPTION:** Y / N

PHONE:_____ **FAX:**_____

_X_ Did the client provide full physical effort?
_X_ Are the client's reports of disability and pain reliable?
_____What are the client's baseline physical tolerances?
_____Other:_____
_____

_____ Is client able to return to the target job?

_____Can the client return to work in a modified capacity?
_____Provide recommendations for work restrictions?
_____ Provide rehabilitation recommendations?

APPOINTMENT DATE:_____ TIME:_____

DATE INFORMATION PACKET MAILED/GIVEN TO CLIENT:_____

DATE SCHEDULED:_____ INFORMATION TAKEN BY:_____

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