Referral Form

Physical & Hand Therapy

Patient Label

Last Name:_____

First Name:_____ MI:_____

Preferred Name (if different):_____

Date of Birth:_____ Sex at Birth: ☐ M ☐ F

Gender Identity:_____ Pronouns:_____

Address:_____ City:_____ State:_____ Zip:_____

Main Ph:_____ ☐ Hm ☐ Work ☐ Cell Alt. Ph:_____ ☐ Hm ☐ Work ☐ Cell

ICD-10 Code:_____ Diagnosis:_____

ICD-10 Code:_____ Diagnosis:_____

ICD-10 Code:_____ Diagnosis:_____

Injury/Surgery Date:_____ Next MD Appt. Date:_____

Physician's Notes:_____

☐ MVA ☐ WC ☐ Personal Insurance:_____
Please attach copy of insurance card.

☐ Insurance on file
Employee Initials_____

☐ Evaluate and treat as indicated. ☐ Evaluate and treat including the following:

- ☐ Home Exercise Program
- ☐ Joint Mobilization
- ☐ Soft Tissue Mobilization
- ☐ Splinting
- ☐ Edema Control
- ☐ Improve Balance
- ☐ Reduce Pain
- ☐ Iontophoresis
- ☐ Post-Op Protocol
- ☐ Increase Range of Motion
- ☐ Increase Strength/Endurance
- ☐ Pelvic Health Therapy

☐ Other:_____

Treat_____ times per week for_____ weeks and/or_____ total visits.

Referring Provider:_____ Practice:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

Provider Signature_____ Date:_____

89 Centennial Loop, Suite 2A, Eugene, OR 97401
(541) 342-1632 ph (541) 636-3478 fax cascadehealth.org