Referral Form

Physical & Hand Therapy

cascade HEALTH

Last Name:_____

First Name:_____ MI:_____

Preferred Name (if different):_____

Date of Birth:_____

Patient Label

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:_____

☐ Motor Vehicle Accident ☐ Worker's Comp ☐ Personal

Please attach copy of insurance card.

Insurance:_____ Subscriber ID: _____

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

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

☐ 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 A, Eugene, OR 97401
(541) 342-1632 ph (541) 636-3478 fax
cascadehealth.org