Referral Form

Cascade Health 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: ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Theirs ☐ Other:_____

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

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

ICD-10 Code:_____ Diagnosis:_____

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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	☐ Splinting	☐ Reduce Pain	☐ Increase Range of Motion
☐ Joint Mobilization	☐ Edema Control	☐ Iontophoresis	☐ Increase Strength/Endurance
☐ Soft Tissue Mobilization	☐ Improve Balance	☐ Post-Op Protocol	☐ 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:_____

PLEASE FAX TO: (541) 636-3478

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