PHYSICAL THERAPY REFERRAL

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KINEMATIX
PHYSICAL THERAPY

Brian D. Jones, DPT

PATIENT INFORMATION

Patient Name:		**DOB:**	
Insurance Carrier:		**Insurance ID:**	
Group #:		**Plan Name:**	
Address:			
Patient Contact Info:			

DIAGNOSIS

Patient Dx:

Surgical? ☐ Yes ☐ No **Surgery Date:**

Procedure:

Date of Injury:

ICD-10 Code(s):

1. **2.** **3.**

Case Type (select one): ☐ Work Comp ☐ No-Fault ☐ PPO / HMO ☐ Medicare / Medicaid

VA / TRICARE, Work Comp, No-Fault & MVA: complete page 2.

ORDERS

- ☐ Eval and Treat
- ☐ Initial Evaluation
- ☐ Therapeutic Activity
- ☐ Neuromuscular Re-Education / Balance
- ☐ Therapeutic Exercise
- ☐ Gait Training
- ☐ Patient Self-Management Education
- ☐ Remote Therapeutic Monitoring (RTM)

Other:

Contraindications:

PLAN OF CARE

Referring Physician:			
Office / Clinic Name:			
Office Phone:		**Office Fax:**	
Frequency:		**Duration:**	
MD Signature:		**MD NPI:**	
Date:			

Work Comp, No-Fault, MVA, VA & TRICARE patients: please also complete the AUTHORIZATION block on page 2.

AUTHORIZATION

Complete the block that matches the patient's coverage, then attach to page 1.

PATIENT REFERENCE

Patient Name: | **DOB:**

WORK COMP / NO-FAULT / MVA

Coverage Type (select one): ☐ Work Comp ☐ No-Fault ☐ Motor Vehicle Accident (MVA)

Insurance Carrier: | **Claim #:**

Date of Injury / Accident: | **Employer (Work Comp):**

Authorization / Approval #: | **Date of Service Approved:**

Auth Start Date: | **Auth End Date:**

 # Visits Authorized:

NURSE CASE MANAGER

NCM Name: | **Phone:**

Fax: | **Email:**

Claim Adjuster:

VA / TRICARE

Program (select one): ☐ Tricare Prime ☐ Tricare Select ☐ Tricare For Life ☐ VA Community Care

Patient Status (select one): ☐ Active Duty ☐ Retiree ☐ Dependent ☐ Veteran

Sponsor Name: | **Sponsor DBN / last 4:**

Beneficiary Category: | **Branch of Service:**

Do not enter the full Social Security Number. Use the sponsor DBN or last 4 digits only.

Authorization / Referral #: | **Episode of Care #:**

Auth Start Date: | **Auth End Date:**

 # Visits Authorized:

PRIMARY CARE MANAGER (PCM) / REFERRING FACILITY

PCM Name: | **PCM NPI:**

Facility Name:

Facility Address:

Facility Phone: | **Facility Fax:**

Authorizing Contact / POC:

Notes: