**PIRS Diagnostic Testing and/or Physical Therapy**

**Referral Sheet**

|  |  |
| --- | --- |
| **Date of Referral:** |  |
| **PIRS #:** *(office use only)* |  |

**General Information:** *(Please complete all information below for each section)*

|  |  |
| --- | --- |
| Type of Referral:CHECK All That Apply: | [ ]  PT [ ]  OT [ ]  FCE [ ]  MRI [ ]  CT [ ]  EMG/NCS [ ]  CHT [ ]  AQT [ ]  Other |

**Patient Information:**

|  |  |
| --- | --- |
| Name of Patient: |  |
| Address: |  |
| DOB: |  |
| SSN: |  |
| Phone #: |  [ ]  Cell [ ]  Home |
| Job Title: |  |

**Employers Information:**

|  |  |
| --- | --- |
| Employer: |  |
| Contact: |  |
| Address: |  |
| Phone #:  |  |

**Injury Information:**

|  |  |
| --- | --- |
| Body Area(s): |  |
| Sub Area: | [ ]  Both [ ]  Left Side [ ]  Lower Half [ ]  Middle[ ]  Right Side [ ]  Total [ ]  Upper Half |
| Date of Injury: |  |
| Diagnosis: |  |
| Has the patient sought medical treatment? | [ ]  Yes [ ]  No |
| If so where: | [ ]  Emergency Room [ ]  Physician [ ]  Other |
| Referring Physician or Facility: |  |
| Referring Physician or Facilities Address: |  |
| Referring Physician or Facilities Phone #: |  |
| Special Instructions: |  |

**WC Insurance Billing Information:**

|  |  |
| --- | --- |
| Company Name: |  |
| Address: |  |
| Phone #:Fax #:  |  |
| Adjuster’s Name: |  |
| Adjuster’s Email: |  |
| Claim Open | [ ]  Yes [ ]  No |
| Claim #: |  |
| **\*\*\*Please answer the following questions when scheduling an MRI: *(please note if this section is not completed the MRI may take longer to schedule)*** | Is the Claimant Claustrophobic? [ ]  Yes [ ]  NoDoes the Claimant have anything metal or foreign in their body? **(Check below)**[ ]  Pacemaker [ ]  Stent [ ]  Shunt [ ]  Surgical implant [ ]  Bullet Injury Has the claimant ever done grinding and welding of metal and suffered an eye injury? If so, was the metal removed? [ ]  Yes [ ]  No Has an MRI been done since? [ ]  Yes [ ]  NoHas the claimant had surgery to the body part being scanned? [ ]  Yes [ ]  NoHas the claimant had surgery within the last 6 months? [ ]  Yes [ ]  NoDoes the claimant have a personal history of [ ]  cancer, [ ]  diabetes,[ ]  hypertension [ ]  kidney disease? [ ]  Yes [ ]  NoDoes the claimant have any allergies to iodine or latex? [ ]  Yes [ ]  NoIf so please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_For women, is there any chance of pregnancy? [ ]  Yes [ ]  NoWhat is your approximate height and weight? HT: \_\_\_\_\_\_\_\_ WT: \_\_\_\_\_\_\_\_\_  |