**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  No  Does 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  No  Has the claimant had surgery to the body part being scanned?  Yes  No  Has the claimant had surgery within the last 6 months?  Yes  No  Does the claimant have a personal history of  cancer,  diabetes,  hypertension  kidney disease?  Yes  No  Does the claimant have any allergies to iodine or latex?  Yes  No  If so please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  For women, is there any chance of pregnancy?  Yes  No  What is your approximate height and weight? HT: \_\_\_\_\_\_\_\_ WT: \_\_\_\_\_\_\_\_\_ |