CULLMAN REGIONAL | Medical Group

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PHYSICAL MEDICINE & REHABILITATION REFERRAL FORM

Patient Name: _____

DOB: _____ Phone #: _____ Cell #: _____

Height: _____ Weight: _____

Address: _____

Insurance Carrier: _____

Policy #: _____

Referral authorization # if required _____

No workup required to refer a patient but please indicate which tests have already been completed.

DIAGNOSIS / INDICATIONS

○ **Spine:** □Neck pain □Thoracic pain □Low back pain □Radiculopathy/sciatica □Stenosis □Disc herniation/DDD □SI joint dysfunction

○ **Upper Extremity MSK:** □Shoulder (rotator cuff/impingement, adhesive capsulitis) □Elbow (epicondylitis) □Wrist/hand pain □Carpel tunnel □Ulnar neuropathy □Other_____

○ **Lower Extremity MSK:** □Knee Pain/OA □Hip pain/OA/bursitis □Ankle/foot pain □Plantar fasciitis □Tendinopathy/overuse □Other_____

○ **Neurologic/EMG:** □Radiculopathy □Mononeuropathy (CTS, ulnar, peroneal) □Plexopathy/nerve injury

○ **Medical/Neurological Debility:** □Gait/balance impairment □Stroke/TBI □SCI □Amputee □Neuropathic Pain □Debility

○ **Spasticity/Botox:** □Post-stroke □SCI □TBI □CP □Functionally limiting tone □Consider botox

○ **Procedures:** □Trigger point injection □Joint/US-guided injection □EMG*/NCS

*After the procedure, please indicate whether you would like Dr. Patel to assume management of this condition or perform the procedure only: _____

○ **Other:** _____

ORDERING PROVIDER

Physician: _____

Phone #: _____ Fax #: _____

Provider Signature: _____

Appointment Date/Time: _____ Patient notified on: _____

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures