ADVANTAGE Healthcare Systems

Healthcare for injured workers.

Patient Referral and Intake Form

Date _____ Referring Doctor _____

Pt. Last Name _____ First _____

Address _____

City _____ State_____ Zip Code _____

Home Phone _____

Alternate Phone _____

Treating Doctor _____

Date of Injury/ Accident _____

Employer _____

Address _____

Work Phone _____

Insurance Type (Circle) W/C Private Ins P/I

Insurance Company _____

Adjuster _____

Address _____

City _____ State _____ Zip _____

Claim Number _____

Phone Number _____

Diagnosis (ICD-10 Codes) _____

Diagnosis (ICD-10 Codes) _____

DOB _____ M ____ F ____ SSN _____

Medical Records Included □ Yes □ No

Treatment Options (Required)

_____ Brain Injury Program
_____ Chronic Pain Program
_____ Functional Restoration Program
_____ Outpatient Medical Rehab Program
_____ Work Hardening/ Work Conditioning
_____ Functional Capacity / Physical Performance Exam
_____ Physical Therapy/ Occupational Therapy
_____ Pain Management Eval and Treatment
_____ Psychiatric Eval & Treatment
_____ Neurologist Evaluation and Treatment
_____ Neuro Psychological Eval & Treatment
_____ Psychological Evaluation for _____
_____ EMG/NCS ____ EEG
_____ Evaluation & Treatment

Major Recommendations:

_____Increase Strength / ROM / Endurance
_____Increase the patient's ability to self-manage pain and related problems.
_____ Reduce/eliminate the use of ongoing healthcare services for primary pain complaints
_____Minimize treatment cost without sacrificing quality of care
_____Reduce the misuse, overuse, or dependency on medications.
_____Maximize and maintain optimal physical activity and function
_____Return to productive activity at home, socially, and/or at work
_____Reduce subjective pain intensity
_____ Post-concussion treatment

Other: _____

Current Treatment Plan: _____

_____

Facility Locations

Canton, TX
Dallas, TX
Fort Worth, TX
☐ Metairie, LA
☐ Waxahachie, TX
☐ San Antonio, TX

With this signature, I certify the above-prescribed treatment is medically reasonable and necessary.

Physician Signature: _____ **Date:** _____

Physician's Printed Name: _____ **NPI#:** _____

www.advantagehcs.com

Scheduling: 877-487-8289 Referral Fax Number: 888-600-9834

All