



# ADVANTAGE

## Healthcare Systems

### Patient Referral and Intake Form

<b>For Inter-Office Use:</b>	
<b>Marketing Representative:</b>	Initials: _____
Verification Date: _____	Initials: _____
Schedule Date: _____	Initials: _____
Evaluation Date: _____	Initials: _____

Healthcare for injured workers.

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    3rd Party    P/I

Insurance Company \_\_\_\_\_

Adjuster \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Claim Number \_\_\_\_\_

Phone Number \_\_\_\_\_

Diagnosis (Codes) \_\_\_\_\_

Diagnosis (Codes) \_\_\_\_\_

DOB \_\_\_\_\_ M \_\_\_\_ F \_\_\_\_ SSN \_\_\_\_\_

Medical Records Included             Yes     No

#### Treatment Options

- |   |   |
|---|---|
| <input type="checkbox"/> Independent Med Exam/ Impairment Rating (W/C ) | <input type="checkbox"/> EMG/NCS (W/C & MM & PI)                |
| <input type="checkbox"/> Biofeedback (W/C & MM)                         | <input type="checkbox"/> Functional Capacity (W/C & MM)         |
| <input type="checkbox"/> Psychological Evaluation (W/C & MM)            | <input type="checkbox"/> Physical Performance Exam (W/C & MM)   |
| <input type="checkbox"/> Interdisciplinary Pain Management (W/C & MM)   | <input type="checkbox"/> Physical Rehab (W/C & MM & PI)         |
| <input type="checkbox"/> Work Conditioning/ Work Hardening (W/C & MM)   | <input type="checkbox"/> Evaluation & Treatment (W/C & MM & PI) |
| <input type="checkbox"/> Individual Counseling (W/C & MM)               | <input type="checkbox"/> Occupational Therapy (W/C & MM & PI)   |

#### Major Recommendations:

- |  |  |
|--|--|
| <input type="checkbox"/> Increase Strength / ROM / Endurance   | <input type="checkbox"/> Reduce the misuse, overuse, or dependency on medications.       |
| <input type="checkbox"/> Increase the patient's ability to self-manage pain and related problems.            | <input type="checkbox"/> Maximize and maintain optimal physical activity and function    |
| <input type="checkbox"/> Reduce/eliminate the use of ongoing healthcare services for primary pain complaints | <input type="checkbox"/> Return to productive activity at home, socially, and/or at work |
| <input type="checkbox"/> Minimize treatment cost without sacrificing quality of care                         | <input type="checkbox"/> Reduce subjective pain intensity                                |

Other: \_\_\_\_\_

Current Treatment Plan: \_\_\_\_\_

#### Facility Locations

- |   |  |
|---|--|
| <input type="checkbox"/> 1. <b>Canton</b> 300 S. Main Street, Canton, TX 75103      | <input type="checkbox"/> 4. <b>Fort Worth</b> 1051 Haskell, St # 200, Fort Worth, TX 76107 |
| <input type="checkbox"/> 2. <b>Dallas</b> 214 W. Colorado Blvd, Dallas, Texas 75208 | <input type="checkbox"/> 5. <b>San Antonio</b> 6521 San Pedro Ave. San Antonio, TX 78216   |
| <input type="checkbox"/> 3. <b>Ennis</b> 507-B S. Clay St., Ennis, TX 75119         | <input type="checkbox"/> 6. <b>Tyler</b> 508 E. Front St. Tyler, TX 75702                  |

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

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_ NPI#: \_\_\_\_\_

[www.advantagehealthcaresystems.net](http://www.advantagehealthcaresystems.net)

**Scheduling: 877-487-8289**

**Referral Fax Number: 888-600-9834**

**Dallas Fax Number: 214-234-8606**