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 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 (Required)

_____ Chronic Pain Program
_____ Functional Restoration Program
_____ Outpatient Medical Rehab Program
_____ Work Hardening/ Work Conditioning
_____ Physical Therapy/ Occupational Therapy
_____ Pain Management
_____ EMG/NCS
_____ Functional Capacity / Physical Performance Exam
_____ Independent Med. Exam/Impairment Rating
_____ Psychological Evaluation for _____
_____ Individual Counseling/ Biofeedback
_____ 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

Other: _____

Current Treatment Plan: _____

_____

Facility Locations

□ 1. **Canton** 300 S. Main Street, Canton, TX 75103
□ 2. **Dallas** 214 W. Colorado Blvd., Dallas, TX 75208
□ 3. **Ennis** 2200 Physicians Blvd., Ste: D, Ennis, TX 75119
□ 4. **Fort Worth** 1300 W. Rosedale, Ste. A, Fort Worth, TX 76104
□ 5. **San Antonio** 6521 San Pedro Ave., San Antonio, TX 78216

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

Physician Signature: _____ **Date:** _____

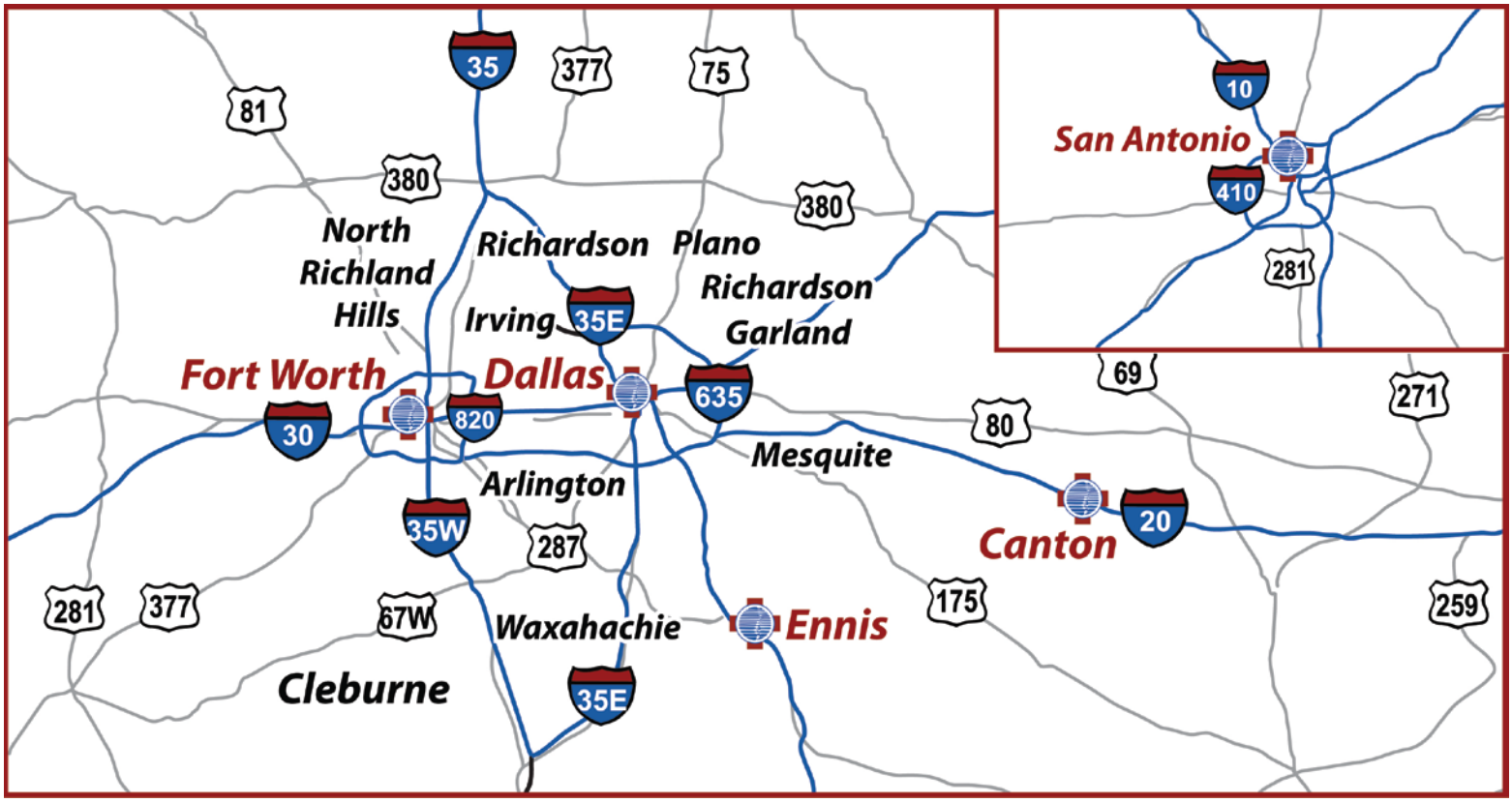
Physician's Printed Name: _____ **NPI#:** _____

www.advantagehcs.com

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

Dallas Fax Number: 214-234-8606

D.E



LOCATIONS TO SERVE YOU:

Dallas – Fort Worth – Ennis – Canton – San Antonio

Attachments:

- □ **MRI**
- □ **EMG/NCV**
- □ **Designated Doctor Exam**
- □ **Orthopedic Consult**
- □ **Medical/Pain Management Consult**
- □ **Functional Capacity Exam/PPE**
- □ **Psychological Eval**
- □ **Individual Counseling**
- □ **ESI Notes**

Notes:

_____

_____

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