PCE/WORK HARDENING REFERRAL FORM

(PLEASE CIRCLE APPROPRIATE PROGRAM)

Today's Date ____________________

Client Name ____________________ ❑ Male ❑ Female (please check one)

Address: ____________________ Phone: ____________________

Accepted Conditions/Doctor's Diagnosis ____________________

Doctor okayed to test to tolerance? ____________________

Claim Number: ____________________ DOI: ____________ Employer: ____________

Referral Source: ____________________ Phone: ____________ Fax: ____________

Address: ____________________

Claims Manager: ____________________ Phone: ____________ Unit: ____________

Address: ____________________

Program Approved? ____________________ Interpreter Needed? ____________________

Bill To: ____________________ Address: ____________________

Send copies to:

Dr. ____________________ Address: ____________________

VRC: ____________________ Address: ____________________

Other: ____________________ Address: ____________________

Other: ____________________ Address: ____________________

Will JA's be sent? ____________________ If so, when? ____________________

Comments/Notes to Evaluator:

____

____

Time and Date PCE/WH Scheduled: For: ____________________ Location: ____________________

Please return this form to:

214 Ash St. • Grandview, WA 98930 • (509) 882-3111 • Fax (509) 882-3362 • grandviewpt.net

WE WILL CALL YOU THE SAME DAY (IF POSSIBLE) WITH AN APPOINTMENT TIME FOR YOUR PCE OR WORK HARDENING PRO