RIW | Rehabilitation Institute of Washington, PLLC

Commission on Accreditation of Rehabilitation Facilities
Member Since 1985

REFERRAL FORM

Please Fax to (206) 859-5031. Please attach any supporting documents or records.

PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Home Phone _____

City, State, Zip _____ Cell Phone _____

Primary Insurance _____ Policy/Claim Number _____

Contact Name _____ Phone Number _____

Secondary Insurance _____ Policy/Claim Number _____

Contact Name _____ Phone Number _____

Diagnosis\Reason for Referral: _____

Multidisciplinary Program Evaluation:

□ Brain Injury Rehabilitation Program
□ Concussion Clinic
□ Pain Management Program
□ Work Rehabilitation Program

Individual Evaluations and Therapy Services (check all that apply):

□ Rehabilitation Medicine Evaluation/Treatment
□ Occupational Medicine Evaluation/Treatment
□ Neuropsychological Evaluation
□ Psychological Evaluation/Treatment
□ Behavioral health assessment/intervention (BHI)
□ Speech Therapy
□ Physical Therapy
□ Occupational Therapy
□ Other: _____

Comments:

_____

REFERRAL SOURCE INFORMATION

Provider's Name: _____ Office Phone: _____

Clinic name and Address: _____ Office Fax: _____

Provider Signature: _____