MedStar Union Memorial Hospital

201 East University Parkway
Baltimore, MD 21218-2895

DATE

PLACE PATIENT ID STICKER HERE

CURTIS WORK REHABILITATION SERVICES
REFERRAL INFORMATION

Referred For A Only or A & T, Ergonomic Consult

Authorized for A Only or A & T, Ergonomic Consult

Client: ______________________ DOB: ______________________
Address: ______________________
City/State: ______________________ Zip Code: ______________________
Phone (Day): ______________ (Eve): ______________ SSN: ______________
Primary Dx: ______________________

Referral Source (Counselor, Physician, Claims Adjuster, Nurse, Other ______________________ (circle one):
Name: ______________________ Address: ______________________
City/State: ______________________ Zip Code: ______________________
Phone: ______________________ (Fax): ______________________
Is this Commission Ordered? Yes/No

Physician:
Name: ______________________ Address: ______________________
City/State: ______________________ Zip Code: ______________________
Phone: ______________________ (Fax): ______________________

Type of Insurance: ______________________
Insurance Co.: ______________________
Claims Adjuster: ______________________
Address: ______________________
City/State: ______________________ Zip Code: ______________________
Phone: ______________________ (Fax): ______________________
Claim #: ______________ WCC#: B - ______________ DOI: ______________

Service Authorized?: Yes No
By Whom?: ______________________ Date: ______________________

Rehabilitation Specialist (Counselor or Nurse): ______________________
Address: ______________________
City/State: ______________________ Zip Code: ______________________
Phone: ______________________ (Fax): ______________________

Employer: ______________________ Contact Person: ______________________
Address: ______________________
City/State: ______________________ Zip Code: ______________________
Phone: ______________________ (Fax): ______________________

Occupation ATOI: ______________________

Is goal to return client to same job?: Yes / No

If no, what is goal? ______________________

Attorney: ______________________
Address: ______________________
City/State: ______________________ Zip Code: ______________________
Phone: ______________________ (Fax): ______________________

Medical Requested?: Yes / No Received?: Yes / No
Medical Clearance Requested?: Yes / No Received?: Yes / No
Referral taken by: ______________________ Date: ______________________

THE ABOVE REPORT IS ADVISORY ONLY.