TNATIOUS TRAINING LLC

PATIENT REFERRAL FORM

Date: _____ / _____ / _____

BRIDGING THE GAP BETWEEN REHAB DISCHARGE AND INDEPENDENT LIVING™

REFERRING PROVIDER INFORMATION

Provider Name: _____

Practice / Facility Name: _____

Specialty:

- ☐ Primary Care
- ☐ Physical Therapy
- ☐ Chiropractic
- ☐ Orthopedics
- ☐ Neurology
- ☐ Pain Management
- ☐ Sports Medicine
- ☐ Other: _____

Phone: _____

Fax: _____

Email: _____

NPI (Optional): _____

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ / _____ / _____

Phone Number: _____

Email: _____

REASON FOR REFERRAL (Check all that apply)

- ☐ General Strength & Conditioning
- ☐ Post-Rehabilitation Exercise
- ☐ Fall Prevention
- ☐ Balance Training
- ☐ Mobility Improvement
- ☐ Functional Strength
- ☐ Weight Management
- ☐ Chronic Pain Management Through Exercise
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Stroke Recovery
- ☐ Joint Replacement Recovery
- ☐ Sports Performance / Return to Sport
- ☐ Injury Prevention
- ☐ Return to Work
- ☐ General Wellness
- ☐ Other: _____

RELEVANT MEDICAL HISTORY / DIAGNOSIS

Please include relevant medical history, surgery, diagnosis, and current condition.

_____

_____

_____

_____

_____

ICD-10 Code(s) (Optional): _____

CURRENT RESTRICTIONS / PRECAUTIONS

- ☐ None
- ☐ Weight Bearing Restrictions
- ☐ Range of Motion Restrictions
- ☐ Blood Pressure Precautions
- ☐ Cardiac Precautions
- ☐ Balance Concerns / Fall Risk
- ☐ Neurological Precautions
- ☐ Post-Surgical Precautions
- ☐ Other: _____

_____

_____

GOALS FOR CONTINUED EXERCISE

- ☐ Improve Strength
- ☐ Improve Mobility
- ☐ Improve Balance
- ☐ Increase Endurance
- ☐ Maintain Rehab Progress
- ☐ Improve Independence
- ☐ Reduce Pain
- ☐ Return to Recreation / Sport
- ☐ Return to Work
- ☐ Other: _____

COMMUNICATION PREFERENCES

Please keep me informed regarding:

- ☐ Initial Evaluation
- ☐ Monthly Progress Reports
- ☐ Significant Changes
- ☐ Program Completion / Discharge Summary
- ☐ Please Contact Only if There Are Concerns

Preferred Method: ☐ Email ☐ Fax ☐ Phone

Other Instructions: _____

_____

ADDITIONAL INFORMATION / COMMENTS

Include any additional information that may assist in developing a safe and effective exercise program.

_____

_____

_____

_____

_____

_____

PROVIDER SIGNATURE

_____ Signature

_____ / _____ / _____ Date

PATIENT ACKNOWLEDGMENT (Optionall)

I understand that this program is not a substitute for medical treatment.
I will inform my trainer of any changes in my medical condition.

_____ Signature

_____ / _____ / _____ Date