MEDICINE

240 East 38th Street • 16th Floor • New York, NY 10016
Telephone: (212) 263 -6033 • Website: www.ruskinstitute.org

Outpatient Adult Physical Therapy Referral Form

FAX to the ACC RUSK INTAKE / REGISTRATION at (212) 263-0113

Date: ___________________________

Patient Name: (Last)______________________________(First)____

Date of Birth:____________________ Gender (Please Circle) F M Social Security:___________________

Patient Address: ____

Patient Phone: (H)_____________________(W)______________________) (C___________________

Primary Insurance:____

Policy ID#:____Insured Name:____________________________

Secondary Insurance:_______________________________________

Policy ID#:____Insured Name:_________________________

Medical Diagnosis _______________________________________ ICD code:____________________________

Physical Therapy Evaluation and Treatment including (please select):

‘ Therapeutic Exercise

‘ 0 D Q X D O 7 K H U D S \

‘ * D L W 7 U D L Q L Q J

‘ 0 R G D O L W \ L Q F O X G L Q J H O H F W U L F D O V W L P X O D W L R Q

‘ 2 W K H U B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B B

Onset Date:__________________

Precautions: ____

Physician's Name/Specialty (Please Print) ____

NPI#: __________________________ License Number:__________________ UPIN:__________________

Physician's address:____

Office Telephone(_______)________________________ Office Fax: (_______)________________________

Physician's Signature: ____