Aquatic Fitness, Inc.

Work-Comp Referral Intake Sheet

☐ CC
☐ OF
☐ New
☐ Old
☐ Male
☐ Female

Referral Date: _____

Script Date: _____

Referred By: _____

Therapist: _____

Next Appt w/ physician: _____

Patient Information

Name: _____

Address: _____

_____

Phone #: _____

Work/Cell #: _____

D.O. B.: _____ D.O.I: _____

SSN #: _____

Employer Information

Name: _____

Address: _____

_____

Phone #: _____

Contact: _____

Job Title: _____

Job Status: _____

Rehab Company Information

Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Case Mgr: _____

Physician Information

Name: _____

NPI #: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Contact: _____

Diagnosis: _____

_____

_____

_____

_____

Surgeries: _____

_____

Frequency: _____

Insurance Information

Name: _____

Address: _____

_____

Phone #: _____

Fax #: _____

Claims Rep: _____

Claim #: _____

CHECKLIST		AUTHORIZATION		COMMENTS/SPECIAL INSTRUCTIONS			
Welcome Letter:	X	Name:					
Med Auth:	X	Date/Time:					
Ins Auth:	X	**PROVIDER NETWORK (if known)**					
Patient Contacted:	X	Name:		**APPOINTMENT**			
Directions Given:	X			Date:		Time:	

Revised:1/08/09