Home & Community Recreation Therapy

Referral Form

Client Name:	Birthdate:
Address:	Date of Loss:
Home Phone:	Cell:
Email (if any):	
Family Contact:	Phone:
Legal Guardian:	Phone:

Diagnosis Code/s:	
Referring Physician:	
Address:	
Phone:	Fax:
ATTACH COPY OF ORDERS TO THIS REFERRAL	

Loss is result of an	☐ Auto Injury	☐ Worker's Comp Injury
Insurance Co:		Claim #:
Insurance Address:		
Adjuster:		Phone:
Adjuster email:		Fax:
Coordinated Medical Claims must provide copy of front and back of Health Insurance Card		

Case Manager:		Email:
Address:		
Cell:	Phone:	Fax:

Reason for referral:
Please attach any records that will assist RT in treatment such as evaluations, CM notes, OT/PT, etc.

Fax referral to 734-222-1877 or email Diane@hcrt.net