

Charlotte Institute of Rehabilitation (CIR)

Referral and Prescription Form

1100 Blythe Blvd., Charlotte, NC 28203-5814

Phone: 704-355-0547 Fax: 704-355-7873

FROM:

Fax: 704-632-6001

Other _____

Physician:

Patient Account number (if applicable) HBOC _____ **IDX** _____

Patient Name: _____ **Sex** _____ **DOB** _____

Address: _____ **City** _____ **State** _____ **Zip** _____

Phone: (H) _____ (W) _____ (C) _____

S.S# _____ ****Diagnosis: (ICD9 Code)** _____ **(Must Have)**

Does Patient Require Interpreter Services Y N **Indicate Dialect** _____

Emergency Contact: _____ **Phone:** _____

Relationship (Circle): Parent Spouse Other

Primary Insurance _____ **Phone** _____ **Group #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Policy Holder _____ **Relationship (Circle):** Self Spouse Child **Policy #** _____

Secondary Insurance _____ **Phone** _____ **Group #** _____

Address _____ **City** _____ **State** _____ **Zip** _____

Policy Holder _____ **Relationship (Circle):** Self Spouse Child **Policy #** _____

PRESCRIPTION: *If this area is completed, a separate prescription is NOT necessary.*

Service Requested (Circle): Physician PT OT ST Therapy & Physician Audiology
Psychology Neuropsychology Wheelchair Seating

Services Ordered: Please write the requested service (provided on the cover sheet).

Frequency: _____ Duration: _____

Treatment or Specified Goals: _____

Physician Signature: _____ **Date:** _____

This sheet must accompany the FAX REFERRAL COVER SHEET for CIR.

(Revised 04/01/04)