OUTPATIENT SERVICES REFERRAL FORM

REHABILITATION HOSPITAL OF INDIANA

***Location Requested (please check location box below):**

❑ **RHI Eagle Highlands**
Inpatient and Outpatient Services
4141 Shore Drive
Indianapolis, IN 46254
Ph.: 317-329-2138 Fax: 317-329-2280

❑ **RHI-Northwest Brain Injury Center**
Specializing in Brain Injury
9531 Valparaiso Court
Indianapolis, IN 46268
Ph.: 317-879-8940 Fax: 317-872-0914

❑ **RHI-Carmel Outpatient Service**
12425 Old Meridian St., Ste. B2
Carmel, IN 46032
Ph.: 317-566-3422 Fax: 317-566-9111

***Please refer to back side for Specialized Services offered at specific locations**

REQUIRED INFORMATION

- Prescription Form
- Relevant Labs, Imaging and Pathology Reports
- Patient Demographics/Insurance
- Surgical Reports, Physician Progress Notes, Chemotherapy and Radiation Therapy Reports (if applicable)

PATIENT INFORMATION

Name: _____ **Phone:** _____ **DOB:** _____/_____/_____

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

Medical Diagnosis: _____ **Associated ICD-10:** _____

Reason for Referral/Rehab Diagnosis: _____

Needs Interpreter ☐ Yes ☐ No If yes, please specify language _____

REQUESTED SERVICES (Please check at least one)

☐ Evaluate and Treat
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech-Language Pathology

☐ Neuropsychology
☐ Psychology
☐ Physiatry Consult

☐ Resource Facilitation
☐ Other _____

Instructions, Precautions, Goals, Allergies, Comments, Other: _____

(Please check if additional services or procedures are indicated)

SPECIALTY THERAPY SERVICES:

- ☐ Brain Injury Community Re-Entry Program
- ☐ Day Treatment Program (pending qualification)
- ☐ Driving Rehabilitation
- ☐ Dry Needling
- ☐ High Intensity Gait Training
- ☐ LSVT BIG
- ☐ LSVT LOUD
- ☐ Motion Analysis Center (Gait Lab)
- ☐ Post Concussion Services
- ☐ Swallowing
  - ☐ Modified Barium Swallow Study
  - ☐ Clinical Swallowing Evaluation
- ☐ Vestibular and Balance Retraining
- ☐ Vision Rehabilitation
- ☐ Wheelchair Seating and Positioning Clinic
- ☐ Other _____

NEUROPSYCHOLOGY SERVICES:

- ☐ Consult
- ☐ Comprehensive Eval & Treat
- ☐ Brain Injury Coping Skills

PHYSIATRY SERVICES:

- ☐ Spasticity Clinic
- ☐ Spinal Cord Clinic
- ☐ Spine and Musculoskeletal Clinic
- ☐ Stroke Clinic
- ☐ Therapeutic Botox Clinic

INJECTIONS:

- ☐ Epidurals
- ☐ Selective Nerve Root
- ☐ Facet Joint/MBB
- ☐ Sacroiliac Joint
- ☐ Trigger Point
- ☐ Other: _____

PROVIDER SIGNATURE/INFORMATION

Today's Date: _____

Special Instructions: _____

Physician's Printed Name _____ **NPI #** _____

Physician's Signature _____ **Next M.D. Appointment Date:** _____

Sender's Phone: _____ **Sender's Fax:** _____

(***Original Signatures Only – No Stamps Allowed***)