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W/C HEALTH INS. PERSONAL INJURY Medicare OTHER _____

PATIENT NAME: _____ DATE: _____

HOME PHONE #: _____ MALE FEMALE

WORK PHONE #: _____ DATE OF INJURY: _____

CELL PHONE #: _____ DATE OF BIRTH: _____

TREATING PHYSICIAN: _____ PHYSICIAN PHONE #: _____
FIRST AND LAST NAME FAX# _____

DIAGNOSIS WITH ICD 9 CODES: _____

EVALUATION

- MEDICAL EVALUATION
- PHYSICAL THERAPY EVAL & TREAT
- FUNCTIONAL CAPACITY EVALUATION (FCE)
- CARPAL TUNNEL EVALUATION
- WORK COMP
- SECOND OPINION/ CASE REVIEW
- IMPAIRMENT RATING
- OTHER _____

NEURODIAGNOSTIC

NCV = LOWER / UPPER

PSYCHOLOGICAL SERVICES

PLEASE NOTIFY US TO FAX YOU THE LETTER OF MEDICAL NECESSITY

- PSYCHOLOGICAL ASSESSMENTS
- INDIVIDUAL PSYCHOTHERAPY
- BIOFEEDBACK ASSESSMENT (PPA)
- BIOFEEDBACK
- STRESS MANAGEMENT

PLEASE FAX PATIENT DEMOGRAPHICS AND NECESSARY CLINICAL INFORMATION ALONG WITH THIS REFERRAL.

PROGRAMS

- PHYSICAL THERAPY ____X____ WKS
 - WORK HARDENING ____X____ WKS
 - WORK CONDITIONING ____X____ WKS
- CHRONIC PAIN MANAGEMENT PROGRAM FOR
 - DISC DECOMPRESSION
- CARPAL TUNNEL DECOMPRESSION
- MANIPULATION
- MASSAGE THERAPY ____ X ____ WKS
 - GAIT TRAINING
 - INFRARED THERAPY

DIAGNOSTIC TESTING

- RANGE OF MOTION
- COMPUTER MUSCLE TESTS
 - PHYSICAL PERFORMANCE TEST
- GRIP & PINCH TEST
 - NIOSH (ISOMETRIC) TEST

SPECIAL INSTRUCTIONS

PLEASE PROVIDE US WITH THE INFORMATION BELOW:

TAX ID #: _____

UPIN #: _____

NPI #: _____

PHYSICIAN'S SIGNATURE: _____