COUNTY OF LOS ANGELES

RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER
Rancho Rising

DEPARTMENT OF HEALTH SERVICES

Date Referred:	
Date Rec'd:	

Does this patient have a DHS ORCHID MRN?
☐ NO ☐ Yes, **MRN:**

Patient Name:				**DOB:**	
Phone Day:	( )	**Phone Cellular:**	( )	**Contact Person Name:**	

Evaluate, Develop Treatment Plan and Treat to address problems related to:

DIAGNOSIS:

ICD-10 Codes (Required):

ONSET DATE:

RELEVANT MEDICAL HISTORY (also include recent H&P):

TO ADDRESS PROBLEMS RELATED TO:

PRECAUTIONS:

☐ **OCCUPATIONAL THERAPY** ☐ **PHYSICAL THERAPY** ☐ **SPEECH THERAPY**	**REASON FOR REFERRAL:** ☐ Rehab: Neuro/Developmental ☐ Rehab: Orthopedic ☐ Rehab: Pediatric (ST only) ☐ Rehab: Amputation ☐ Balance & Vestibular (PT) ☐ Pelvic Floor Dysfunction (PT) ☐ Other:
☐ **SEATING CENTER (PT)** * Copy of Face-to-Face Examination Documentation **is required** and must accompany this referral.	**REASON FOR REFERRAL:** ☐ New Cushion/Pressure Sore ☐ New Seating System / Accessories / Modifications ☐ New Manual Wheelchair ☐ New Power Mobility Device/Wheelchair **DATE OF FACE-TO-FACE EXAMINATION:** **LENGTH OF NEED FOR WHEELCHAIR:** ☐ **Temporary** Need ☐ **Lifetime** Need
☐ **CART (all OT, PT, & ST)** Center for Applied Rehabilitation Technology	**REASON FOR REFERRAL:** ☐ Seating and Mobility ☐ Access to Computer/Mobile Devices ☐ Environmental Controls ☐ Augmentative and Alternative Communication
☐ **VOCATIONAL SERVICES (OT)**	**REASON FOR REFERRAL:** ☐ Basic Computer Skills ☐ Return to a Specific Job ☐ Community Re-Entry ☐ Worksite Evaluation ☐ Functional Capacity Evaluation ☐ Work Exploration

Medical Provider Information:

REFERRING PROVIDER NAME:		**PHONE #:**	
ADDRESS:		**FAX #:**	
LICENSE #:	**NPI #:**	**EMAIL:**	

REFERRING PROVIDER SIGNATURE	DATE

Please return this form and the Patient Information form to Rancho Outpatient Referral Office
Telephone: (562) 385-7111, ext. 56536
Fax: (562) 385-7826
OutpatientTherapy@dhs.lacounty.gov

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(Rancho Only)

(Affix Zebra HIM or Zebra FIN Label Here)