

**RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER  
COMMUNITY REFERRAL – OUTPATIENT THERAPY**

Date Referred:
Date Rec'd:

<b>Does this patient have a Rancho #?</b>
<input type="checkbox"/> NO <input type="checkbox"/> Yes, Number:

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

<input type="checkbox"/> <b>OCCUPATIONAL THERAPY:</b>	Appointment Date/Time:
<input type="checkbox"/> <b>PHYSICAL THERAPY:</b>	Appointment Date/Time:
<input type="checkbox"/> <b>SPEECH THERAPY:</b>	Appointment Date/Time:
<b>Evaluate, Develop Treatment Plan and Treat to address problems related to:</b>	
<b>DIAGNOSIS (Required):</b>	<b>ONSET DATE (Required):</b>
<b>RELEVANT MEDICAL HISTORY:</b>	
<b>PRECAUTIONS (Required):</b>	
<b>PRIORITY:</b> <input type="checkbox"/> Urgent (ASAP) <input type="checkbox"/> Routine	
<b>REASON FOR REFERRAL (Choose ONE):</b> <input type="checkbox"/> Rehabilitation – Neuro Dx <input type="checkbox"/> Rehabilitation – Orthopedic	
<input type="checkbox"/> OUTPATIENT <input type="checkbox"/> Rehabilitation – Amputation <input type="checkbox"/> Rehabilitation – Pediatric	
<b>TO ADDRESS PROBLEMS RELATED TO:</b>	

**Medical Provider Information:**

<b>REFERRING PROVIDER NAME (Please Print):</b>	<b>PHONE #:</b>
<b>ADDRESS</b>	<b>FAX #:</b>
<b>LICENSE #:</b>	<b>NPI #:</b>
	<b>EMAIL:</b>

<b>REFERRING PROVIDER SIGNATURE</b>	<b>DATE</b>

**\* DO NOT USE this form to make a referral for Inpatient Rehabilitation Evaluation. Please contact the Referral Office at (562) 401-6536.**

**\* Please return this form and the Patient Information form to:  
Rancho Outpatient Referral Office  
Telephone: (562) 385-7111    Fax: (562) 385-7826  
Email: [OutpatientTherapy@dhs.lacounty.gov](mailto:OutpatientTherapy@dhs.lacounty.gov) (please send encrypted)**

MRUN
NAME
DOB/GENDER

