



**ACC - RUSK REHABILITATION**

240 East 38<sup>th</sup> Street • 16<sup>th</sup> Floor • New York, NY 10016

Telephone: (212) 263-6033 • Website: [www.ruskinstitute.org](http://www.ruskinstitute.org)

**Outpatient Vocational Rehabilitation Referral Form**

FAX to the ACCRUSKINTAKE/ REGISTRATION at (212) 263-0113

Date: \_\_\_\_\_

Patient Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender (Please Circle): F M Social Security: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Patient Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Primary Insurance: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

Prescription for Vocational Rehabilitation (please select):

- \_\_\_\_\_ Assessment
- \_\_\_\_\_ Treatment
- \_\_\_\_\_ Other: \_\_\_\_\_

Onset Date: \_\_\_\_\_

Pertinent Medical History \_\_\_\_\_

Precautions: \_\_\_\_\_

Physician's Name/Specialty (Please Print) \_\_\_\_\_

NPI#: \_\_\_\_\_ License Number: \_\_\_\_\_ UPIN: \_\_\_\_\_

Physician's address: \_\_\_\_\_

Office Telephone (\_\_\_\_\_) \_\_\_\_\_ Office Fax: (\_\_\_\_\_) \_\_\_\_\_

Physician's Signature: \_\_\_\_\_