Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

PT/OT REFERRAL FORM

This form is an optional communication tool

To Therapist: This referral is to increase patient's functional ability emphasizing active care and self-reliance. Further referral depends upon achievement of functional improvement goals.

For
- ☐ Progressively Increasing Activity/Exercise
- ☐ Increase Activity Tolerance
- ☐ Develop home/Self-care program
- ☐ Work Activity Conditioning
- ☐ Other

Staff of Provider Complete

Worker's name	Accepted Condition(s) *Include ICD Codes*	DOI	Claim #

Worker's Occupation	Current Work Status (*Attach your most recent Activity Prescription Form if available*)
	☐ Full Duty ☐ Not working for medical reasons ☐ Modified Duty ☐ Not working – light duty not available
Claim Manager's (CM) Name	Phone / ☐ CM Notified of Referral ☐ Other CM Assistance requested

Attending Provider's Name	Phone	Therapist's Name	Phone

Business Address	Business Address
	Appointment Date / Appointment Time

Employer's Name	Phone

Employer's Address

Accommodation (*if not full duty*) ☐ Available/Possibly Available (*Mark all that apply*)
- ☐ Modified Duty
- ☐ Temporary Job
- ☐ Part Time/Graduated Duties
- ☐ Work Station or Job Modification
- ☐ Not Available
- ☐ Unknown

Provider Complete

Known Work Exposure Concerns (*Mark all that apply*)
- ☐ Repetitive Work
- ☐ Heavy Lifting
- ☐ Awkward Positions
- ☐ Repetitive Bending
- ☐ Prolonged Sitting
- ☐ Other

Potential Contraindications for Care

Therapy Goals (*Mark all that apply*)
- ☐ Increased activity tolerance
- ☐ Increased range of motion
- ☐ Increased activity duration
- ☐ Strengthening of injured region
- ☐ Increased capacity for specific activity
- ☐ Other:

Interventions Already Used for This Episode
- ☐ Active self-care (exercise instruction/handouts)
- ☐ Activity diary/log
- ☐ Physical (manipulation, massage/muscle work)
- ☐ Physical/occupational therapy
- ☐ Medications/injections
- ☐ Surgery
- ☐ Specialty referral:

Progress to Date
- ☐ No change since care was initiated
- ☐ Symptom improvement:
- ☐ Functional gains:
- ☐ Other:

Expected Follow-up From Therapist at 2 week intervals:
- Progress report of functional activity goals and attainment
- Patient compliance with PT/OT visits and home activities
- Recommendations for further care
- If return-to-work not achieved, schedule call to discuss impediments and further options

Other:

Attending Provider's Signature	Date

AP: Copy the signed form to send to L&I and give the following section to worker

A physical/occupational therapy appointment has been made for you with:

Name	Appointment Date	Appointment Time

Address

Phone

I understand that failure to complete this referral may jeopardize future benefits on my claim.

Worker's Signature

Date