Initial Evaluation Referral Request Form for Rehabilitation Sports Medicine at Sea View Pediatrics – Laguna Hills

Scheduling :714.639.4990 ext.32982(English) 32983(Spanish) Fax:714.744-3841

Thank you for referring your patient to the Rehabilitation Sports Medicine Program at Sea View Pediatrics – Laguna Hills. To better serve you and your patient, please provide us with the following information by fax.

- ☐ **This COMPLETED Form**
- ☐ **Patient Demographics**
- ☐ **Copy of Insurance Card**
- ☐ **Legible Medical Records/Clinical Notes supporting the reason for the referral and diagnosis**
- ☐ **Insurance Authorization made out to: Rady Children's Restorative Care, including CPT or HCPC codes for the requested referral**

Patient Information

Patient Name: _____ Date of Birth: ____/____/____

ICD 10/Chief Complaint: _____

Parent/Guardian Primary Language: _____ Patient Primary Language: _____

Please indicate the services you are requesting and ensure all codes are included on the authorization:

☐ **Physical Therapy Evaluation** (CPT: 97161, 97162, 97163 or Medi-Cal: X3920-1, X3922-8)

Physician Stamp

(Provider Name, Address, Phone No., Lic., NPI)

Provider Signature: _____ **Date:** _____ **Time:** _____