ACC - RUSK INSTITUTE OF REHABILITATION MEDICINE
240 East 38th Street • 16th - 17th Floors • New York, NY 10016
Telephone: (212) 263-6033 • Website: www.ruskinstitute.org

Outpatient Adult Multidisciplinary Therapy Referral Form

FAX to the ACC RUSK INTAKE / 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:______________________________

Prescription for: (please select departments) You **must** include a diagnosis

____Physical Therapy- **Diagnosis**:____

____Vestibular Therapy- **Diagnosis**:____

____Occupational Therapy General- **Diagnosis**:____

____Speech and Language Pathology- **Diagnosis**:____

____Psychology/Neuropsychology- **Diagnosis**:____

____Vocational Rehabilitation- **Diagnosis**:____

____Social Work- **Diagnosis**:____

____Swallowing Center- **Diagnosis**:____

____Other_________________ **Diagnosis**: ____

Prescription for: (please select)
_____Evaluation or
_____Evaluation and Treatment
Additional Comments: ____
____

Physician's Name/Specialty (Please Print) ____

NPI#: ___________________________ License Number:__________________ UPIN:__________________

Physician's address:____

Office Telephone: (______)_______________________ Office Fax: (______)________________________

Physician's Signature: ____