



Rancho Los Amigos
National Rehabilitation Center

Rancho Los Amigos National Rehabilitation Center

Seating Center Referral Patient Information

Name (Last, First Middle Initial)

Address (Street, City, State, Zip)

Home Phone

Cell Phone

<input type="text"/>	<input type="text"/>
----------------------	----------------------

Sex

Race

Religion

Primary Language

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------

Birthplace

Marital Status

Mother's Maiden Name

<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------

Emergency Contact Name

<input type="text"/>	Emergency Contact Address: Phone Number:
----------------------	---

Relationship to patient

Insurance Provider Information

Medi-Cal #
Medi-Cal Issue Date

Medicare #
Medicare Issue Date

Other insurance

Please fax this form along with the Seating Center Referral Form to:
Outpatient Therapies Department
Fax: 562-401-6052 Phone: 562-401-6847



Rancho Los Amigos
National Rehabilitation Center

Rancho Los Amigos National Rehabilitation Center

Seating Center Referral Prescription

Patient Name

DOB

Does this patient have a Rancho #?

Y/N

Number:

Referring MD Name

License #

Phone #

Fax #

Diagnosis

Significant PMH

Rx: Physical Therapy Seating Center Evaluation: Evaluate and treat

Reason for Referral

Precautions

MD Signature

Date

Please fax this form along with the Patient Information Form to
Outpatient Therapies Department
Fax: 562-401-6052 Phone: 562-401-6847