DLT Department of Labor and Training
RHODE ISLAND

Arrigan Rehabilitation Center

249 Blackstone Boulevard, Providence, RI 02906-5815
Phone: (401) 243-1200 | Fax: (401) 222-3887 | Web: www.dlt.ri.gov/arrigan

For timely processing, referrals require a medical diagnosis, signature of referring medical provider, date of referral, attachment of most recent medical report(s) and completion of the information below. We will report regularly on the progress of your patient. **Please fax this completed referral to 401-222-3887.**

Referral For:

Patient's Name: _____ Last 4 digits of Soc. Sec.# _____ Date of Referral:_____

Date of Birth: _____ Patient's Phone Number: _____ Patient's Email: _____

Address (Street, City/Town, State, Zip): _____

Insurance Company: _____ Case Manager: _____ Date of Injury: _____

Telephone: _____ Patient's Employer: _____

Date of Surgery (if needed): _____ Interpreter Needed? ○ Yes ○ No If yes, what language? _____

Referral For: (Check One Only): ○ Evaluation & Treatment as per Arrigan Center recommendation OR
○ Evaluation & Treatment ONLY as indicated below

Physical and Occupational Therapy:
- ☐ Therapeutic Exercises
- ☐ Body Mechanics Training
- ☐ Splint Fabrication

☐ Aquatic Therapy
(Physical Therapy or Occupational Therapy)

☐ Comprehensive Pain Management Program
(Includes P.T., O.T., Psychological, Medical and Vocational Services)

☐ Functional Capacity Evaluation (FCE)
(Please specify below if restrictions apply)

Work-Site Services:
- ☐ Ergonomic Assessment/Consult
- ☐ Symptom Management Coaching
- ☐ Body Mechanics Instruction

☐ Work Hardening (Progressive Work Simulation)

☐ Psychological Consult

☐ Vocational Services/Consult
Patient Released to Work: ○ Yes ○ No
(Please specify below if restrictions apply)
- ☐ 5-Week Work Readiness Program
- ☐ English as a Second Language Program

Diagnosis(es):

Requesting Additional Feedback On (Date): _____

Clinical Restrictions:

Medical Provider's Signature:

Signature: _____ Date: _____

Name (Print): _____ Telephone: _____