TEXAS WORKFORCE COMMISSION (TWC) REFERRAL FORM

Physical Therapy and Rehab Clinic, Inc

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Houston, TX 77057

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info@ healthriteclinic.com
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Date:

Consumer's Name:

Consumer's Phone#:

Consumer's Disabilities:

Requestor's Name:

Requestor's Phone#:

Field Office:

Please be advised that the consumer will be scheduled for the requested evaluation stated below and a Notification of Appointment Letter will be forwarded by email/mail. Please call our office if you have any questions.

WE APPRECIATE YOU CONSIDERING US FOR THIS REFERRAL.

☐ Physician's Visit	99204	1 unit
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Drug Screen	80307	1 unit
Drug Screen Clinical Pathology	80500	1 unit
☐ Physical Therapy Evaluation	97162	1 unit
☐ Occupational Therapy Evaluation	97166	1 unit
☐ Functional Capacity Evaluation	97750	20 units
☐ Home Modification	DRS50	20 units
☐ Work Hardening Initial 2hrs	97545	10 units
Additional hours	97546	20 units

PLEASE SELECT THE REASON FOR FUNCTIONAL CAPACITY EVALUATION.

- ☐ To assess whether an injured patient can return to a previous job.
- ☐ To assess the client's safe work tolerance levels, the job is unspecified.
- ☐ To assess the client's ability to perform a specific job. (Please list below)

Specific Job Title:

Comments:

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