PRESCRIPTION: FUNCTIONAL RESTORATION PROGRAM REFERRAL/TREATMENT REQUEST

Patient's Name: _____ Date of Injury: _____
Diagnosis: _____

I am requesting a functional restoration program for my patient. I am considering my patient for possible placement in a multidisciplinary, It is my judgment a comprehensive evaluation, mental health/pain psychological evaluation, recent functional capacity evaluation, and physician pain management specialist evaluation.

This patient is suffering from a work related injury. It is my judgement, as treating doctor, problems as detailed below, are preventing and/or interfering with the patient's recovery and functional capacities, including those required for return to work. This comprehensive evaluation will allow me to establish a specific treatment plan for the patient based on the patient's physical capacities, level of pain and coping strategies, motivational levels, problematic psychological and psychosocial factors, etc.. I believe it is **medically necessary** this evaluation be complete as soon as possible.

Provide me with your evaluation report of the patient's current functioning related to my concerns (at least **2** must be indicated in accordance with T.W.C.C. Mental Health Treatment Guidelines):

__X__ **LIMITED/INADEQUATE TREATMENT RESPONSIVENESS:** The patient has not responded to primary or secondary stages of outpatient physical therapy and/or mental health treatment in a reasonable period of time (e.g., within 4 to 6 months)

__X__ **PAIN PROBLEMS:** The patient exhibits pain behavior, functional limitations, and/or mental/emotional dysfunction, which are disruptive to their activities of daily living, and **two** or more of the following:

- __X__ **DURATION:** Pain persisting beyond the expected tissue healing time
- _____ **DRAMATIZATION:** The patient has physical/mental impairment greater than expected on the basis of the diagnosed medical condition and treatment
- _____ **DYSFUNCTION:** The patient is facing significant, permanent loss of functioning that requires major physical, vocational, and psychological readjustment
- _____ **DEPENDENCY:** The patient continues to express unrealistic expectations regarding outcome of medical/psychiatric intervention to relieve their symptomatology
- _____ **DIA NOSTIC DILEMMA:** Diagnostic findings are insufficient to explain the pain **or** further invasive medical treatment is **not** an option
- _____ **DEPENDENCY:** The patient has a documented history of inappropriate and/or excessive use of healthcare services
- _____ **DRUGS:** The patient has a documented history of inappropriate and/or excessive use of narcotic, sedative-hypnotic medications, alcohol, or other self-medication
- _____ **DYSFUNCTION:** The patient has chronic pain linked to adverse interpersonal relationships which interfere with rehabilitation
- _____ **DISUSE:** Physical functional capacity deficits by impairments in strength, range of motion and/or endurance
- __X__ **D SFUNCTION/RETURN TO WORK IMPAIRMENTS:** Unable to perform prior work/job, no job to return to, patient fired, and/or other return to work obstacles
- _____ **DEPRESSION:** By psychological, behavioral, physical/vegetative, and/or other symptoms of depression **or** other significant mental stress symptoms

__X__ **FUNCTIONAL CAPACITY EVALUATION** to determine current physical functioning level for Functional Restoration Program / Post Physical Performance Evaluation after initial 20 days

_____ _____-_____-_____
Doctor's Signature oday's Date

Fax to: Nueva Vida Behavioral Health Associates-Functional Restoration Program
Fax: (855) 616-0829; Phone: (210) 616-0828