



# Apricus Specialty Solutions Referral Form

Phone Fax

Fields highlighted in red are required.

## Referral Information:

Person Making Referral: Phone: Referral Date:

Choose One: DC Planner Case Manager Adjuster Other

Adjuster Name (If Available): Phone:

Email Address:

Claim Number: IW Employer Name:

Physician Name:

Physician Address:

City: State: ZIP:

Attorney: Firm Name:

Attorney Phone: Attorney Email:

## Injured Worker Information:

First Name: Last Name:

Diagnosis Code:

Phone: Date of Birth: Gender: M F

Address:

City: State: ZIP:

Delivery Address/Contact (If Different From Above):

City: State: ZIP:

## Hospital Discharge and/or Facility Planning

Surgery? Y N If Yes, Surgery Date: (or) Discharge Date: in AM PM

Facility Name: Phone: Fax:

Facility Address:

City: State: Zip:

Email Address:

## Additional Facility Care Management

<b>LTAC</b>	<b>Skilled Facility</b>	<b>Nursing Home</b>	<b>Other</b>
<hr/>			
<b>Facility Name:</b>	<b>Phone:</b>	<b>Fax:</b>	
<hr/>			
<b>Facility Address:</b>			
<hr/>			
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	
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<b>Email Address:</b>			
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## Services Requested

<b>Weight: lbs.</b>	<b>Height: Feet</b>	<b>Inches</b>	
<b>Durable Medical Equipment</b>		<b>Orthotics &amp; Prosthetics</b>	<b>Respiratory Services</b>
<b>Home Health Care</b>		<b>Hospital Discharge Planning</b>	<b>Electrical Stimulation Devices</b>
<b>Diagnostic/Imaging Services</b>		<b>Home/Vehicle Modifications</b>	<b>TENS Supplies</b>
<b>Medical Transportation</b>		<b>Hearing Aids</b>	<b>Bone Growth Stimulation</b>
<b>Interpretation/Translation</b>		<b>Mobility Devices</b>	<b>Facility Care Management</b>
<b>Catastrophic Care</b>		<b>Medical Supplies</b>	<b>Physical Medicine</b>

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After clicking Submit, an email will open where you can attach prescriptions and any additional information or documentation to support this request.