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### PRIME Referral Information

Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ Parent/Guardian to Contact if Minor: \_\_\_\_\_  
Patient DOB: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Referring Clinician: \_\_\_\_\_ PT ATC CSCS DC OD DDS  
Other: \_\_\_\_\_  
Email: \_\_\_\_\_ Phone: \_\_\_\_\_ **Permission to contact patient directly? Y / N**

Have you attended PRI Courses? Y / N If yes, what is the patient's habitual PRI pattern? Check all that apply:  
L AIC B AIC (PEC) R BC B BC R TMCC B TMCC  
PRI Tests you feel are pathologic: \_\_\_\_\_

**Please answer the following questions to the best of your ability, based on your professional opinion and interaction with the patient. If unknown, leave blank:**

Why are you making this referral?  
\_\_\_\_\_

What are the top two musculoskeletal pain patterns or other symptoms expressed by the patient?  
\_\_\_\_\_

What circumstances does the patient express that make their symptoms worse? (eg: sitting, standing, computer/desk work, running, or other treatment/intervention attempts) \_\_\_\_\_

Are there any new symptoms or symptoms that are getting worse as you have intervened with this patient?  
\_\_\_\_\_  
\_\_\_\_\_

Does the patient wear: Glasses Contacts Hearing Aids Shoe Inserts Mouth Appliance  
If "yes" to shoe inserts or mouth appliance, were either under your direction, and if yes, please describe the type of insert/appliance and what the objective and subjective outcome(s) were:  
\_\_\_\_\_  
\_\_\_\_\_

What significant trauma(s), if any, has the patient experienced?  
\_\_\_\_\_

Do they have a history of ankle difficulties, including injuries, sprains, instability, plantar fasciitis or heel cord tightness? If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_

What significant surgeries, if any, has the patient had? \_\_\_\_\_  
\_\_\_\_\_

Does their vision change during or after physical activities? If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

Do they have visual complaints that are difficult to resolve or seem sensitive to small changes? \_\_\_\_\_  
\_\_\_\_\_

Is there anything else you feel we should know about this patient? \_\_\_\_\_  
\_\_\_\_\_