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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 you 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? _____

_____