PT NORTHWEST

Request to Return to Care

Name: ____ Diagnosis: ________________________________
(Last Name, First Name)

____
(Reason for rehabilitation services)

Referral Source: ☐ Medical Provider ☐ Self Referred Provider Name: ______________________________
(MD, DO, PA, NP, etc)

Describe the reason or situation for the missed appointment that lead to being discharged from care:

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I, ____, am requesting consideration to return as a patient to PT Northwest, LLC, and continue or start up a new case to receive physical rehabilitation services. I agree and understand that it is my responsibility as the patient to adhere to the cancel / no show policy set forth by PT Northwest. I acknowledge that if I am unable to adhere to the policy I am subject to be discharged as a patient again and that communication back to my provider will take place in compliance with PT Northwest policy.

Patient Signature: ______________________________________ Date: ___________________

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Internal Use Only: Date Received: ________________

Reviewed by: ____

☐ Request Approved ☐ Request Denied

Communication with Patient done by: _________________________________ Date: ___________________

☐ Email ☐ Phone ☐ In Person

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