Colorado Rehabilitation & Occupational Medicine (CROM)
Autonomic Testing Battery & Infrared Stress Thermography
Referral Form

Referring Physician:___________________________ *Signature*:_________________________

Address:_________________________________ City:______________ State:_________ Zip:______

Phone: ____________________ Fax: _________________Contact Name:______________________

Practice Name: ___________________________ Date: ________________________________

***Test Requested* (circle one):** ATB Infrared Stress Thermography Both

Patient Name:________________________________ DOB: _________Email Address:_____________

Address: _____________________________ City: _________________ State:________ Zip:________

Phone (home):________________ (work):____________________ (Cell):______________________

Insurance Information:

Carrier: ____ Phone:____________________________

DOI: ________________ Claim #:____________________

Adjuster Name:______________________________ Phone:______________________

Has Authorization been obtained? YES NO

By who: ________________ Date obtained: _________________ Authorization number: _________

Please scan and email this form to*: CRPS@coloradorehab.com*

Or fax to: *(303)306-2425*

To facilitate the appointment process, it would be helpful if you can include the information below, as it will be required in any case before the actual appointment

* Patient's current mediations
* Your initial medical evaluation, the most current visit note, and any other medical information you believe would be helpful
* Imaging studies (if applicable)

For info call: *(303) 306-2482*