RADIOGRAPH REFERRAL COVER SHEET
(TO BE COMPLETED BY RESEARCH STUDY PARTICIPANTS AT THE TIME OF REFERRAL FOR RADIOGRAPH)

Fax this cover sheet AND a copy of the completed *Referral for Radiograph by PT* to 1-888-368-0176.

Referral Date	
Patient's Last Name	

Under what authority are Physical Therapy services being delivered to this patient?	☐ Referral to PT from PCP
	☐ Referral to PT from Specialist
	☐ Direct Access
	☐ Other (please describe)

Imaging Provider Selected by the Patient (if known)	☐ Rhode Island Medical Imaging	Location:
	☐ XRA Medical Imaging	Location:
	☐ Advanced Radiology	Location:
	☐ Tollgate Radiology	n/a
	☐ Other (please state name and location)	

Describe any issues or concerns with making this referral for a radiograph	

Other Comments	

NOTES ON HIPPA COMPLIANCE:

The fax number noted on this form uses a HIPAA compliant secure TLS 1.2 for transport, and AES 256 encryption, with a dedicated e-portal only available to study staff.