DMC
Rehabilitation Institute of Michigan

Return to: Rehabilitation Institute of Michigan
Center for SCI Recovery
261 Mack Boulevard
Detroit, Michigan 48201
Ph: 313-745-9932
Fax: 313-745-1174

Center for Spinal Cord Injury Recovery

APPLICATION FORM

Date: Month/_____ Day/ _____ Year/ _____

First Name: _____

Last Name: _____

Address: _____

_____

City: _____

State: _____ **Zip Code:** _____

Social Security No: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Date of Birth: Month/____ Day/ ____ Year/ _____

Country: _____

Emergency contact Information:

Name: _____

Relationship: _____

Phone Number: _____

E-mail Address: _____

PCP (PRIMARY CARE PHYSICIAN):

Name: _____

Address: _____

Phone Number: _____

Specialty: _____

ALLERGIES:

_____

_____

TYPE OF INSURANCE:

Name: _____

Address: _____

Phone Number: _____

Policy/Claim #: _____

Contact Person: _____

Case Manager: _____

Case Manager #: _____

Date of Injury: Month/____ Day/ ____ Year/ _____

Cause of Injury: _____

Level of Injury: _____

Height: _____ **Weight:**_____

Sex: ☐ Male ☐ Female

Complete: _____ **Incomplete:** _____

ASIA (If Known):

_____

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PHYSICIAN'S REFERRAL FORM

PATIENT: PLEASE HAVE YOUR PHYSICIAN COMPLETE THE FOLLOWING MEDICAL INFORMATION ABOUT YOU.

PHYSICIAN: IF YOU WOULD LIKE TO REFER YOUR PATIENT TO A RIM SUB-SPECIALIST IN SCI MEDICINE, PLEASE CHECK HERE: ☐ YES ☐ NO

Patient's Name: _____ **Date:** _____

Dear Doctor,

Your patient has indicated an interest in participating in the high intensity rehabilitation program at RIM's Center for Spinal Cord Injury Recovery.

The program includes vigorous exercise (e.g., aerobics, isometric/isotonic strengthening), weight bearing through all four limbs, stretching, electrical stimulation of paralyzed muscles, and other physical therapy modalities, such as ultrasound, hot packs, iontophoresis, etc.

Please help us ensure that your patient can safely participate in these activities by completing the following questionnaire and indicate any restrictions you deem to be appropriate.

Thank you in advance for your consideration. We would be happy to assist you as needed.

NEUROLOGICAL: Does your patient have any neurological diagnoses other than SCI? Please describe:

CARDIOVASCULAR: Does your patient have any risk factors which may impact his/her ability to exercise safely at high intensity (~METS)? Please describe:

PULMONARY: Does your patient have any pulmonary disease? Please describe:

MUSCULOSKELETAL: Does your patient have any musculoskeletal condition which might impact his/her ability to exercise or engage in weight bearing thru his/her arms and legs? A bone density exam is recommended for injuries greater than 12 months post injury. Please describe:

PSYCHOLOGICAL: Does your patient have psychological symptoms which could impact on his or her participation in an intensive rehabilitation program? Please describe:

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PAIN: Does your patient have any pain management issues that could impact on his or her participation in an intensive rehabilitation program? Please describe:

INTEGUMENTARY: Does your patient have integumentary issues which could impact on his or her participation in an intensive rehabilitation program? Please describe:

MISCELLANEOUS: Does your p[patient have any other medical or rehabilitation issues that were not addressed above?

Please note: The Center for Spinal Cord Injury Recovery is suited for individuals who have completed their inpatient and traditional outpatient rehabilitation.

Physician's Name: _____

Physician's Signature: _____ **Date:** _____