OUTPATIENT THERAPY TREATMENT

REFERRAL REQUEST

To Physician/Nurse Practioner: _____ Date:_____

Phone:_____ Fax: _____

Patient Name: _____ DOB: _____

Patient Address: _____ Phone: _____

_____

Patient POA (name, contact):_____

Primary Insurance: _____ Policy #:_____ Group #:_____

Secondary Insurance: _____ Policy #:_____ Group #:_____

Diagnosis/Reason for Referral/Additional Notes

Discipline to Evaluate and Treat
☐ Physical Therapy (PT) ☐ Occupational Therapy (OT) ☐ Speech Therapy (SLP)

☐ Gait Training/Balance ☐ Cognitive skills development/retraining

☐ Strengthening ☐ LSVT BIG/LOUD Training

☐ Pain Management ☐ Lymphedema Treatment

☐ Neuromuscular Reeducation ☐ ADL Training/Safety

☐ Treatment for Swallowing, Speech, and Voice Dysfunction

☐ Other: _____

☐ Verbal Order Received on behalf of:_____ Received by:_____

Clinician Placing order's Signature_____ Date:_____

Physician Signature_____ Date Signed: _____

FAX BACK TO: ADVANCED THERAPY SERVICES 847-999-6722

If possible, please also fax back the patient's last progress note/history and physical