

OUTPATIENT REHAB REFERRAL FORM

ORTHO/NEURO/GENERAL

PATIENT NAME: _____ DATE: _____

PATIENT PHONE #: _____ DOB: _____

DX: _____ INSURANCE: _____

COMMENTS/INSTRUCTIONS: _____

 EVALUATE & TREAT AS INDICATED

SERVICES		WORKER'S COMP		OTHER SERVICES	
THERAPEUTIC EXERCISE		WORK CONDITIONING		HAND THERAPY	
ROM		FCE (FUNCTIONAL CAPACITY EVAL)		CUSTOM SPLINTING	
PASSIVE ONLY		IR (IMPAIRMENT RATING)		ADAPTIVE EQUIPMENT TRAINING	
ACTIVE ASSISTIVE		MODALITIES		AQUATIC THERAPY	
ACTIVE		OF CHOICE		VESTIBULAR REHAB	
ADL TRAINING		HEAT/COLD THERAPY		TMJ	
FLEXIBILITY		US/PHONOPHORESIS		PELVIC FLOOR REHAB	
STRENGTHENING		PARAFFIN		BIG AND LOUD (PARKINSON'S)	
GAIT TRAINING		IONTOPHORESIS		KT TAPING	
BALANCE/COORDINATION		TRACTION		WOUND CARE	
MYOFASCIAL RELEASE/ MASSAGE		CERVICAL LUMBAR		SPEECH THERAPY	
MANUAL THERAPY/MOBILIZATION		FLUIDOTHERAPY		EVAL & TREAT	
SPINE STABILIZATION		ELECTRICAL STIMULATION		COMMUNICATION PROBLEM	
CERVICAL LUMBAR/SI		NMS		DYSPHAGIA	
BACK CARE EDUCATION		TENS		NMES/VITAL STIM	
POSTURAL RETRAINING		DRY NEEDLING		MBS STUDY	
OTHER:		OTHER:		OTHER:	
PROGRAMS					
BACK PROGRAM		CERVICAL PROGRAM		SHOULDER PROGRAM	
KNEE PROGRAM		ANKLE PROGRAM		FIBROMYALGIA PROGRAM	
LYMPHEDEMA PROGRAM		HOME EXERCISE PROGRAM		OTHER:	
FREQUENCY/DURATION:		AT THERAPIST'S DISCRETION			
		CIRCLE CHOICE: 1 2 3 4 5 X/WK FOR 2 4 6 8 WEEKS			
PHYSICIAN'S SIGNATURE: _____				PHYSICIAN'S PHONE #: _____	

TO SCHEDULE AN APPOINTMENT CALL (256) 737-2271

PLEASE BRING THIS FORM WITH YOU TO THERAPY