



**THERAPY REFERRAL FORM**

Patient's Name: \_\_\_\_\_ Date of Referral: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

**EVALUATE & TREAT**  **PHYSICAL THERAPY**  **OCCUPATIONAL THERAPY**  **SPEECH THERAPY**  
 (per approved Plan of Care)

**PT/OT:**

- |  |   |
|--|---|
| <input type="checkbox"/> Activities of Daily Living (ADLs) | <input type="checkbox"/> Neuromotor Re-education        |
| <input type="checkbox"/> Adaptive Equipment                | <input type="checkbox"/> Oral Motor/Feeding             |
| <input type="checkbox"/> Balance Training                  | <input type="checkbox"/> ROM (PROM, AAROM, AROM)        |
| <input type="checkbox"/> Fine Motor Coordination           | <input type="checkbox"/> Sensory Integration            |
| <input type="checkbox"/> Functional Activities             | <input type="checkbox"/> Soft Tissue Mobilization       |
| <input type="checkbox"/> Gait Training                     | <input type="checkbox"/> Strengthening                  |
| <input type="checkbox"/> Gross Motor Coordination          | <input type="checkbox"/> Therapeutic Exercise           |
| <input type="checkbox"/> Home Exercise Program             | <input type="checkbox"/> Ultrasound                     |
| <input type="checkbox"/> Joint Mobilization                | <input type="checkbox"/> Visual Motor/Perceptual Skills |
| <input type="checkbox"/> Lumbar Stabilization              | <input type="checkbox"/> Wheelchair Assessment          |
| <input type="checkbox"/> Muscle Weakness                   | <input type="checkbox"/> Other: _____                   |

**SPEECH:**

- |  |  |
|--|--|
| <input type="checkbox"/> Articulation/Phonology        | <input type="checkbox"/> Oral Motor/Feeding            |
| <input type="checkbox"/> Cognitive Retraining          | <input type="checkbox"/> Swallowing Therapy/Dysphagia  |
| <input type="checkbox"/> Expressive/Receptive Language | <input type="checkbox"/> Voice and Resonance Disorders |
| <input type="checkbox"/> Fluency/Stuttering            | <input type="checkbox"/> Other: _____                  |
| <input type="checkbox"/> Home Exercise Program         |  |

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PLEASE FAX THIS FORM TO: (469) 917-0799**

*[Confidential Information]* Unless otherwise indicated or obvious by the nature of this transmittal, the information contained in this FAX message is privileged and confidential, intended for the use of the designated recipient (or the employee or agent responsible to deliver to the designated recipient). You are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately via 469.917.0805.