THERAPY OPS
OCCUPATIONAL•PHYSICAL•SPEECH

205 S. Main St.
Suite 1010
Red Oak, TX 75154
P: (469) 917-0805
F: (469) 917-0799
W: therapyopstx.com

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:

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

SPEECH:

☐ Articulation/Phonology
☐ Cognitive Retraining
☐ Expressive/Receptive Language
☐ Fluency/Stuttering
☐ Home Exercise Program
☐ Oral Motor/Feeding
☐ Swallowing Therapy/Dysphagia
☐ Voice and Resonance Disorders
☐ Other: _____

Physician's Signature: _____ Date: _____

Print Name: _____ Clinic Name: _____

Address: _____

Phone: _____ Fax: _____

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