THERAPY OPS
OCCUPATIONAL•PHYSICAL•SPEECH

200 N I-35E Suite C
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: _____

Complete Address: _____

Insurance (Policy & Group #): _____

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

PT/OT:

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

SPEECH:

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

Physician's Signature: _____ Date: _____

Print Name: _____ Clinic Name: _____

Address: _____

Phone: _____ Fax: _____

Fax this completed form to: (469) 917-0799