

## 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:

- |  |   |
|--|---|
| <input type="checkbox"/> Activities of Daily Living (ADLs) | <input type="checkbox"/> Oral Motor/Feeding             |
| <input type="checkbox"/> Adaptive Equipment                | <input type="checkbox"/> ROM (PROM, AAROM, AROM)        |
| <input type="checkbox"/> Balance Training                  | <input type="checkbox"/> Sensory Integration            |
| <input type="checkbox"/> Fine Motor Coordination           | <input type="checkbox"/> Soft Tissue Mobilization       |
| <input type="checkbox"/> Functional Activities             | <input type="checkbox"/> Strengthening                  |
| <input type="checkbox"/> Gait Training                     | <input type="checkbox"/> Therapeutic Activities         |
| <input type="checkbox"/> Gross Motor Coordination          | <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: _____                   |
| <input type="checkbox"/> Neuromotor Re-education           |   |

### SPEECH:

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

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

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

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

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

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

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