PHYSICAL / OCCUPATIONAL THERAPY REFERRAL

PATIENT NAME: ____D.O.B _____________ Phone# ________________

DX: ____ Surgery Date: ___________________________________

Precautions: ____

Provider Impression / Assessment: ____

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Indications / Goals for Referral:

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Service Requested:

[ ] Physical / Occupational Therapy

[ ] Evaluate / Treat as Indicated

[ ] Post-Op Protocols

[ ] Lymphedema Management

[ ] Oncology Rehabilitation

[ ] Splinting

[ ] Therapeutic Exercise:

__Resistive __ Passive __ Active

__Strengthening

__Stretching / ROM

[ ] Manual Techniques / Soft Tissue Mobilization

[ ] Ultrasound / Phonophoresis / Iontophoresis

[ ] Home Program

[ ] Other

Expected Duration: ____________________

Frequency: ___________________________

Referring Provider:

____

Date: ____________