Rehabilitation Services referral form

For ongoing therapy, **fax updated order to 682-885-7590**. Please attached face sheet/insurance sheet to referral.
Please instruct families to call for appointment scheduling. Rehabilitation new patient **scheduling line is 682-885-3898**.

For this order to be processed, please fill out all fields.

Patient name: _____ DOB: _____ Sex: _____

Diagnosis: _____ ICD-10 code(s): _____

Service requested: (please indicate) ○ **PT** ○ **OT** ○ **ST** ○ **AUDIO**

Priority: ○ **Routine** (within 12 weeks) ○ **High** (within two weeks) ○ **Stat** (within 24 weeks)

Physician order: (check all services that apply)

Physical therapy
- ○ Evaluate and treat
- ○ Other

_____

Occupational therapy
- ○ Evaluate and treat
- ○ Other

_____

Pelvic floor therapy
- ○ Evaluate and treat

Speech/Language pathology
- ○ Evaluate and treat
- ○ Feeding/oral motor evaluate and treat
- ○ Swallow function study
- ○ Soft palate study
- ○ Nasopharyngoscopy
- ○ Other

_____

Audiology
- ○ Audiology evaluation and management
- ○ ABR (sedated)
- ○ ABR (unsedated)
- ○ Hearing aid evaluation
- ○ Cochlear implant evaluation
- ○ Vestibular evaluation
- ○ Other

_____

Date of onset/procedure/surgery: _____

Precautions: _____
(Brace requirements, ROM limitations, weight bearing, incision care, fall precautions, allergies, active drainage, etc.)

_____
Physician signature Date/time

_____
Physician name (printed) Physician phone Fax

Special instructions/comments: _____

_____

_____
Contact person at office Phone