

- This form is for DIRECT PT or OT Referral

- For pts with an unclear diagnosis or plan for therapy, Please consider referring them first to orthopedic, neurology, or Rehab (depending on the medical condition) clinic. This would serve to clarify the etiology of the problem, and to obtain more specific instructions for therapy.

Please use 2 separate forms if you are referring pt to both

Patients who may have had PT in the past 6 mo may not qualify for further PT. You can check for this by looking in the visit section of medicis. PT is logged in as Therapeutic 828

These (orange marks) are the standard PT orders for the typical medicine clinic patients.

REHABILITATION MEDICINE SERVICES
OUTPATIENT THERAPY REFERRAL

Location

Clinic CARD IMPRINT

(check one) Physical Therapy
 Occupational Therapy

Pt. Telephone Number

ALL INFORMATION MUST BE COMPLETED FOR THERAPY SERVICES

PUT ONLY PT/OT Related Dx

ICD-9 CODE

DATE OF ONSET AND/OR SURGERY

ATTENDING PHYSICIAN (PRINT)

SURGERY (DESCRIBE)

RESIDENT and BEEPER (PRINT)

CLINIC/SERVICE

EXT.

All v marks should be filled in. Please make sure to include your beeper # and ICD 9 code.

LIST PROBLEM AREAS AND REASONS FOR THERAPY REFERRAL

REASONS/PROBLEMS (PRINT):

PRECAUTIONS/CONTRAINDICATIONS

- please comment on any retirement & hx.
- please note any balance problems

Check here if pt. had therapy within the last six months

THERAPY ORDERS: (Must Be Specific - e.g. site, restrictions, number of treatments and/or dosage)*

Evaluation

Upper Extremity Splint Fitting and Training (type and site)* OT only

Procedures

Lower Extremity Prosthetic/Orthotic Training (type and site)* PT only

Neuromuscular Reeducation (proprioceptive-neuromuscular facilitation, posture, balance)

Checkout for Orthotic and Prosthetic Use

Therapeutic Exercise

Community/Work Reintegration Training

Passive ROM (specify limits)

usually for post-op patients

Modalities - Specify number of treatments:

Active Assisted ROM

Mechanical Traction* PT only

Active ROM

Whirlpool*

Strengthening

Hot/Cold pack*

Stretching

TENS/Electrical Stimulation*

HEP (Home Exercise Program)

Ultrasound*

Manual Therapy Techniques (soft tissue mobilization, joint mobilizations, manual traction, massage)

Phonophoresis* (dosage and medication)

Therapeutic Activities (dynamic activities to improve functional performance)

Iontophoresis* (dosage and medication)

ADL/Self Care/Home Management Training (includes body mechanics instruction)

Vasopneumatic device

Gait Training (including stairs) - PT only

Paraffin baths - OT only

Wheelchair Management

Fluidotherapy* - OT only

Other* (specify)

THERAPY FREQUENCY/DURATION (NOTE: MEDICARE LIMITED TO 30 DAYS)

Frequency/Duration

2 x /week x 4 weeks

All PT Rx last only 4 weeks. You may be asked to fill out or sign another form after 4 weeks.

THERAPY ORDERS MUST BE SIGNED BY THE ABOVE REFERRING PHYSICIAN

REFERRING ATTENDING SIGNATURE

DATE OF REFERRAL

Please have the PIC or your firm attorney sign