THERAPY SERVICES OUTPATIENT REFERRAL

Please select a location for services.
☐ Louisville Rehab Center / 3503 Moyers Circle / Phone 502.753.8850 / Fax 502.259.5290
☐ Shelbyville Rehab Center / 711 Frankfort Road / Phone 502.513.1875 / Fax 502.633.0661

NAME ______________________ DATE ______________

DIAGNOSIS ______________________

ICD-10 DX CODE ______________ NUMBER OF TREATMENTS PER WEEK ______________ NUMBER OF WEEKS ______________

REFERRING PHYSICIAN ______________

GOALS

☐ Relief of pain ☐ Decrease edema ☐ Increase dynamic balance ☐ Improve function
☐ Improve strength ☐ Increase ROM ☐ Improve communication ☐ Improve swallowing

CONTRAINDICATIONS / PRECAUTIONS / SPECIAL INSTRUCTIONS ______________________

WEIGHT BEARING STATUS ______________ LEFT ______________ RIGHT ______________

PHYSICIAN'S ORDERS

☐ Physical therapy (evaluate and treat as indicated)
☐ Occupational therapy (evaluate and treat as indicated)
☐ Speech therapy (evaluate and treat as indicated)
☐ Other ____

Physical Therapy (Check all that apply.)
☐ Therapeutic exercises ☐ Strengthening ☐ Gait training ☐ Ultrasound ☐ Paraffin ☐ TENS
☐ Phonophoresis ☐ Manual therapy ☐ Balance retraining ☐ Iontophoresis ☐ Transfer skills
☐ Postural exercise ☐ Home exercise program ☐ Other ____________________

Occupational Therapy (Check all that apply.)
☐ Therapeutic exercises ☐ Scar massage ☐ ADL training ☐ Joint protection instruction ☐ Splinting
☐ Home exercise program ☐ Electrical stimulation ☐ Paraffin ☐ Manual/Motor wheelchair evaluation
☐ Seating and repositioning ☐ Neuromuscular re-education ☐ Fine motor coordination ☐ Modalities
☐ Other ____________________

INITIAL

Speech Therapy (Check all that apply.)
◻ Oral motor therapy ◻ Expressive/Receptive language therapy ◻ VitalStim ◻ Cognitive therapy
◻ Augmentative and alternative communication ◻ Evaluation and training ◻ Other ____________________

I certify that this patient is under my care and that the above outpatient services are medically necessary.

____ _________________________
PHYSICIAN'S SIGNATURE DATE

____
ID NUMBER