REQUEST FOR REFERRAL

DATE OF REQUEST: _____

TO (PHYSICIAN/NURSE PRACTITIONER): _____

PHONE: _____ FAX: _____

CLIENT'S NAME: _____ SS#: _____

CLIENT'S ADDRESS/FACILITY: _____

CLIENT'S PHONE: _____ CLIENT'S D.O.B.: _____

P.O.A.: _____ CONTACT #: _____

P.O.A. ADDRESS _____

PRIMARY INSURANCE/MEDICARE #: _____

SECONDARY INSURANCE/POLICY #: _____

☐ PT/OT ☐ PT ☐ OT ☐ SLP: EVAL & TREAT _____ x/WEEK _____ x/DAYS

DME ORDER REQUEST

DIAGNOSIS

- ☐ Abnormality of Gait
- ☐ Muscular Wasting/Disuse Atrophy
- ☐ ADL Dysfunction
- ☐ Pain (specify): _____
- ☐ Alzheimer's/Dementia
- ☐ COPD
- ☐ Osteoporosis
- ☐ Dysphagia
- ☐ Lack of Coordination
- ☐ Debility (Deconditioning)
- ☐ DJD (specify): _____
- ☐ Contractures
- ☐ Parkinson's
- ☐ W/C Eval. and Inst.
- ☐ Aphasia
- ☐ Voice Disturbance

MEDICAL PRECAUTIONS:

PLAN OF CARE

- ☐ Therapeutic Exercise (97110)
- ☐ Balance, Coordination, Proprioception, and Postural Training (97112)
- ☐ Orthotic Fitting and Training (97760)
- ☐ Therapeutic Activities to Improve Function (97530)
- ☐ Joint Mobilization (97140)
- ☐ Speech/Hearing Therapy (92507)
- ☐ Cognitive Skills Development (97532)
- ☐ ADL Training/Safety (97535)
- ☐ Wheel Chair Training (97542)
- ☐ Gait Training (97116)
- ☐ Prosthetic Training (97761)
- ☐ Massage (97124)
- ☐ Clinical Driving and On the Road Assessment as Necessary (97537)
- ☐ Treatment and Swallowing Dysfunction and/or Oral Function for Feeding (92526)
- ☐ Caregiver Ed/Skills2 Care
- ☐ Community Mobility Issues
- ☐ Community Integration
- ☐ Home Safety Evaluation
- ☐ Other: _____

LONG-TERM GOALS

1. Patient will improve their ability for: ☐ Transfers ☐ Ambulation ☐ ADLs ☐ Other _____
   to an assistance level of: ☐ SBA ☐ Independence ☐ Other _____
2. Patient will improve their ability for: ☐ Transfers ☐ Ambulation ☐ ADLs ☐ Other _____
   to an assistance level of: ☐ SBA ☐ Independence ☐ Other _____
3. Patient will improve their ability for: ☐ Transfers ☐ Ambulation ☐ ADLs ☐ Other _____
   to an assistance level of: ☐ SBA ☐ Independence ☐ Other _____

ORDER STATUS

☐ VERBAL ORDER ON BEHALF OF: _____ RECEIVED BY: _____

☐ FAXED TO REFERRAL SOURCE FOR SIGNATURE ☐ LEFT AT FACILITY FOR SIGNATURE ☐ OTHER: _____

Clinician Placing Order's Signature

Region

Physician's NPI#

Physician's Signature

Print or Stamp Physician's Name

Date

TIM FOX, PT, DPT, GCS | License #40QA00702100 | 7 Carnegie Plaza, Cherry Hill, NJ 08003

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