REQUEST FOR ORDERS

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**

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/Skills$_2$Care
- ☐ Community Mobility Issues
- ☐ Home Safety Evaluation
- ☐ Other: ____________________

ORDER STATUS

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

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

____
Therapist Placing Order's Signature

____
Physician's Signature

____
Print Name

Region: ____________________

PLEASE FAX BACK TO 1 800 597 0848

PHYSICAL, OCCUPATIONAL, & SPEECH THERAPISTS.

T 1 877 407 3422 | **W** foxrehab.org