

TREATMENT REFERRAL

PSG - MEMBER SERVICES

PATIENT'S NAME: _____ SS#: _____

PATIENT'S ADDRESS: _____

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

MEDICARE PATIENT: MEDICAL BENEFIT TRADITIONAL PART B: Y N

MEDICARE #: _____

SECONDARY INSURANCE: _____

SECONDARY POLICY #: _____

PT / OT PT OT SPEECH: _____ X WEEK _____ X WEEKS

DIAGNOSIS

- | | |
|--|--|
| <input type="checkbox"/> Abnormality of Gait | <input type="checkbox"/> Lack of Coordination |
| <input type="checkbox"/> Muscular Wasting / Disuse Atrophy | <input type="checkbox"/> Debility (deconditioning) |
| <input type="checkbox"/> ADL Dysfunction | <input type="checkbox"/> DJD (specify): _____ |
| <input type="checkbox"/> Pain (specify): _____ | <input type="checkbox"/> Contractures |
| <input type="checkbox"/> Alzheimer's / Dementia | <input type="checkbox"/> Parkinson's |
| <input type="checkbox"/> COPD | <input type="checkbox"/> W / C Eval. and Inst. |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Aphasia |
| <input type="checkbox"/> Dysphagia | <input type="checkbox"/> Voice Disturbance |
- Medical Precautions: _____

EVALUATE & TREATMENT AS INDICATED

- | | | |
|--|--|--|
| <input type="checkbox"/> Therapeutic Exercise (97110) | <input type="checkbox"/> ADL Training / Safety (97535) | <input type="checkbox"/> Caregiver Ed / Skills ₂ Care |
| <input type="checkbox"/> Balance, Coordination, Proprioception and Postural Training (97112) | <input type="checkbox"/> Wheel Chair Training (97542) | <input type="checkbox"/> Community Mobility Issues |
| <input type="checkbox"/> Orthotic Fitting and Training (97760) | <input type="checkbox"/> Gait Training (97116) | <input type="checkbox"/> Home Safety Evaluation |
| <input type="checkbox"/> Therapeutic Activities to Improve Function (97530) | <input type="checkbox"/> Prosthetic Training (97761) | |
| <input type="checkbox"/> Joint Mobilization (97140) | <input type="checkbox"/> Massage (97124) | |
| <input type="checkbox"/> Speech / Hearing Therapy (92507) | <input type="checkbox"/> Clinical Driving and On the Road Assessment as Necessary (97537) | |
| <input type="checkbox"/> Cognitive Skills Development (97532) | <input type="checkbox"/> Treatment and Swallowing Dysfunction and / or Oral Function for Feeding (92526) | |
| <input type="checkbox"/> Other: _____ | | |

I certify these services as medically necessary for the patient's plan of care.

HEALTHCARE PROFESSIONAL NAME: _____

HEALTHCARE PROFESSIONAL ADDRESS: _____

HEALTHCARE PROFESSIONAL PHONE: _____

NPI #: _____

Healthcare Professional's Signature _____ Date _____

PLEASE FAX BACK TO 1 800 597 0848



**PHYSICAL, OCCUPATIONAL,
& SPEECH THERAPISTS.**

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