

THERAPY TREATMENT REFERRAL

FACILITY/RESIDENCE

SOURCE

☐ PCP ☐ HOSPITAL ☐ SNF ☐ SPECIALIST ☐ ACO ☐ BUNDLE

PATIENT INFO (OPTIONAL IF ATTACHING FACE SHEET)

PATIENT NAME: _____ DATE: _____

PATIENT ADDRESS: _____

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

P.O.A. NAME/CONTACT #/ADDRESS: _____

MEDICARE/PRIMARY INSURANCE #: _____

SECONDARY INSURANCE/POLICY #: _____

 IF POST-ACUTE FOLLOW-UP,
EXPECTED DATE OF DISCHARGE:

DIAGNOSIS / REASON FOR REFERRAL / ADDITIONAL NOTES

DISCIPLINE TO EVALUATE & TREAT

☐ PT/OT ☐ SLP SPEECH-LANGUAGE PATHOLOGY ☐ OT OCCUPATIONAL THERAPY ☐ PT PHYSICAL THERAPY

EVALUATE & TREAT AS INDICATED

- | | | |
|--|--|--|
| <input type="checkbox"/> Treatment of Swallowing Dysfunction / Oral Function | <input type="checkbox"/> Upper Extremity Prosthetic or Orthotic Fitting and Training | <input type="checkbox"/> Manual Therapy / Massage |
| <input type="checkbox"/> Treatment of Speech, Voice, and Language Deficits | <input type="checkbox"/> Community Mobility Assessment (where available)* | <input type="checkbox"/> Pain Management |
| <input type="checkbox"/> Cognitive Skills Development | <input type="checkbox"/> Driving Program (NJ, PA, DE) | <input type="checkbox"/> Wheelchair Provision / Training |
| <input type="checkbox"/> Caregiver Education | <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Lower Extremity Prosthetic or Orthotic Fitting and Training |
| <input type="checkbox"/> Dementia Management / Caregiver Training | <input type="checkbox"/> Balance Training | <input type="checkbox"/> Provision of Assistive Device i.e. cane, walker |
| <input type="checkbox"/> LSVT LOUD (where available)* | <input type="checkbox"/> Therapeutic Activity | <input type="checkbox"/> Postural Training |
| <input type="checkbox"/> ADL Training / Safety | <input type="checkbox"/> Coordination Proprioception Training | <input type="checkbox"/> Gait / Endurance Training |
| <input type="checkbox"/> Home Safety Assessment | <input type="checkbox"/> Transfer Training | <input type="checkbox"/> LSVT BIG Training (where available)* |
| | <input type="checkbox"/> Range of Motion | |

☐ OTHER: _____

*Discuss local availability with Account Manager

PHYSICIAN / NP / PA

PRINT OR STAMP NAME: _____ NPI #: _____

ADDRESS: _____ PHONE: _____

SIGNATURE: _____ DATE: _____

☐ EVAL / TREAT AFTER:

SNF / HOME HEALTH PROVIDER: _____ PHONE: _____


 PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY.
FOX REHABILITATES LIVES.

T 877.407.3422 | W foxrehab.org

 PLEASE FAX TO 1.800.597.0848 OR
EMAIL TO ADMIT@FOXREHAB.ORG