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THERAPY TREATMENT REFERRAL

ADDRESS/FACILITY

NAME OF SENDER
ADDRESS LINE 1
ADDRESS LINE 2

SOURCE

☐ PCP ☐ HOSPITAL ☐ SNF ☐ SPECIALIST ☐ ALF ☐ OTHER_____

PATIENT INFO (OPTIONAL IF ATTACHING FACE SHEET)

NAME: _____ SS #:_____ DATE: _____

PHONE: _____ D.O.B.: _____

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

P.O.A. 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

- ☐ Treatment of Swallowing Dysfunction/ Oral Function
- ☐ Treatment of Speech, Voice, and Language Deficits
- ☐ Cognitive Skills Development
- ☐ Caregiver Education
- ☐ Dementia Management/Caregiver Training
- ☐ ADL Training/Safety
- ☐ Home Safety Assessment
- ☐ Upper Extremity Prosthetic or Orthotic Fitting and Training
- ☐ Therapeutic Exercise
- ☐ Balance Training
- ☐ Therapeutic Activity
- ☐ Coordination Propioception Training
- ☐ Transfer Training
- ☐ Range of Motion
- ☐ Manual Therapy/Massage
- ☐ Pain Management
- ☐ Wheelchair Provision/Training
- ☐ Lower Extremity Prosthetic or Orthotic Fitting and Training
- ☐ Provision of Assistive Device i.e. cane, walker
- ☐ Postural Training
- ☐ Gait/Endurance Training
- ☐ **Other:** _____

PHYSICIAN / NP/ PA

PRINT OR STAMP NAME: _____ NPI #: _____

ADDRESS: _____ PHONE: _____

SIGNATURE: _____ DATE: _____

☐ EVAL/TREAT AFTER:

SNF/HOME HEALTH PROVIDER: _____ PHONE: _____

SACRAMENTO REHABILITATION SOLUTIONS INC

PHYSICAL, OCCUPATIONAL & SPEECH THERAPY

T 916.209.0235 | **W** sacrehabsolutions.com

PLEASE FAX TO 1.916.218.6319 OR EMAIL TO INTAKE@SACREHABSOLUTIONS.COM

SACRAMENTO REHABILITATION SOLUTIONS, INC.