OUT-PATIENT REFERRAL FORM
REHAB SERVICES

(Check One)

☐ OCCUPATIONAL THERAPY
☐ PHYSICAL THERAPY
☐ SPEECH THERAPY

PATIENT: ___________________________________________ DATE REFERRED: _________________
MAILING ADDRESS: _______________________________________
BIRTHDATE: ___________________ SEX: ___M ___F TELEPHONE: ________________________________
INSURANCE PLAN/#: ___________________ AUTHORIZATION #__________________________
DIAGNOSIS: ICD-9 CODE(S):
ICD-10 CODE(S):

ONSET DATE: ______________ FREQUENCY OF TREATMENT: ______________ DURATION: ______________
TREATMENT: ___________________________________________________________________________
PRECAUTIONS/SPECIAL INSTRUCTIONS: ___________________________________________________________________________________

______________________________________
Physician’s Signature/Date

Revised 08/2015