THE PT PEOPLE
PHYSICAL, OCCUPATIONAL & SPEECH THERAPY

REFERRAL PAD

Referring Physician/Group: _____ Date: _____
Physician's Phone: _____ FAX: _____
Contact Person: _____
Patient's Name: _____
Diagnosis: _____ CPT Code: _____
Precautions/Weight Bearing Status: _____
Frequency:_____ Duration:_____

- ❑ Physical Therapy Evaluation and treatment
  - ❑ Balance and Fall Prevention Program
  - ❑ Pain Management
  - ❑ Maintenace Program - Prevention/Slowing Down Functional Decline
  - ❑ Functional Mobility Training

- ❑ Occupational Therapy Evaluation and Treatment
  - ❑ Activities of Daily Living Training
  - ❑ Self- Feeding Dressing
  - ❑ Toileting Bathing

- ❑ Speech Therapy Evaluation and Treatment
  - ❑ Swallowing Difficulty
  - ❑ Cognition

- ❑ Continue current Physical Therapy/Occupational Therapy /Speech Therapy Services

Additional comments/notes/instructions:_____
_____

Referring Physician Signature:_____Date:_____

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