3300 South Street, Ste. 203 | Lakewood, CA 90805
Office: (562) 512-3320 | Fax: (562) 381-7763

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: ______________________________________
____
____

Please send medical history and patient's insurance information.

Thank you for your kind referral.