

BIG COUNTRY REHABILITATION, LLC

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PHYSICAL / OCCUPATIONAL THERAPY REFERRAL

Patient's Name: _____ Date of Birth: _____

Address: _____

Referring Physician: _____

Diagnosis: _____ Code: _____

Onset Date: _____ Patient Aware of Dx: Yes No

TREATMENT DESIRED

- | | | |
|--|---|---|
| <input type="checkbox"/> Evaluate and Treat | <input type="checkbox"/> Hot/Cold Pack | <input type="checkbox"/> Manual Therapy |
| <input type="checkbox"/> Cognitive Evaluation | <input type="checkbox"/> Ultrasound/Phonophoresis | <input type="checkbox"/> Soft Tissue |
| <input type="checkbox"/> Pelvic Floor | <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Joint Mobilization |
| <input type="checkbox"/> Vestibular/Concussion | <input type="checkbox"/> IFC/Russian/HVGS | <input type="checkbox"/> Graston/Cupping |
| <input type="checkbox"/> Work Hardening | <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Kinesio Tape |
| <input type="checkbox"/> Adaptive Driving | <input type="checkbox"/> AROM | <input type="checkbox"/> Iontophoresis |
| <input type="checkbox"/> Splint/Orthotic Fabrication | <input type="checkbox"/> PROM/Stretching | <input type="checkbox"/> Traction: Lumbar/Cervical |
| <input type="checkbox"/> Functional Dry Needling | <input type="checkbox"/> Strengthening | <input type="checkbox"/> Wound Care/Negative Pressure |
| <input type="checkbox"/> Aquatic Therapy | <input type="checkbox"/> Gait Training | <input type="checkbox"/> Dressing |
| <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Functional Activities | <input type="checkbox"/> Debridement |

Other _____

Frequency: _____ Duration: 30 DAYS

Goals: _____

Precautions: _____

Effective Date: _____ Signature: _____ Date: _____