Therapy Treatment Referral

Name of Office:________________________________

Office#:________________**Fax#:**________________

Physician Name:________________________________.

Physician NPI#: ________________________________.

Patient Name: **DOB:** **Date:**

Patient Address: **Phone #:**

Primary Insurance Name/#:

Secondary Insurance Name/#:

Primary Medical Diagnosis:

Secondary Medical Diagnosis:

Chief Complaint:

Specific Instructions/Precautions:

****For patients benefiting from a splint, please write the order for Occupational Therapy to evaluate, treat, and splint (specific joint).****

☐ Occupational Therapy Evaluate and Treat as Indicated:

- ▫ ________________________________
  ____
- ▫ M06.9 Rheumatoid Arthritis
- ▫ R26.9 Gait Dysfunction
- ▫ R26.2 Difficulty Ambulating/Walking
- ▫ R27.9 Decreased/Lack of Coordination
- ▫ R25.9 Abnormal Movement
- ▫ R29.6 Repeated Falls
- ▫ Z91.81 History of Falls
- ▫ Z74.1 Assistance with Personal Care
- ▫ R53.1 Activity Tolerance/Weakness
- ▫ M62.81 Generalized Muscle Weakness
- ▫ R29.898 Extremity Weakness
- ▫ R53.1 Decondition/Muscle Weakness
- ▫ M62.49 Contracture of Muscle
- ▫ M25.9 Joint Disorder
- ▫ R27.9 Impaired Coordination/Balance
- ▫ R54 Age-Related Physical Debility
- ▫ M54.9 Dorsalgia, Unspecified
- ▫ R29.3 Abnormal Posture
- ▫ F07Z9UZ Prosthetic/Orthotic Training
- ▫ M79.609 Pain in Unspecified Limb
- ▫ R62.0 Delayed Milestone in Childhood
- ▫ F84.0 Autistic Disorder
- ▫ R62.50 Developmental Delay
- ▫ G80.9 Cerebral Palsy
- ▫ G62.9 Neuropathy
- ▫ R20.2 Numbness and Tingling
- ▫ Z60.2 Problems Related to Living Alone
- ▫ M62.50 Atrophy
- ▫ G30.9 Alzheimer's Disease
- ▫ F32.9 Depression
- ▫ R60.9 Lower Extremity Edema
- ▫ R13.10 Dysphasia

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Physician Signature: **Date:**