ENHANCED
Therapy Services

Referral Form

Patient Name: _____ D.O.B _____

Patient Phone Number: _____ Follow up date: _____

Diagnosis/ICD-10 (Code) _____

Additional information related to treatment: _____

_____

❑ Physical Therapy - Evaluate and Treat

❑ Occupational Therapy - Evaluate and Treat

❑ Speech Therapy - Evaluate and Treat

Specialty Services

❑ Blood Flow Restriction Therapy (PT only)

❑ Dry Needling (PT only)

❑ LSVT BIG (PT only)

❑ Lymphedema (OT only)

❑ FEES-Swallow Study (ST only)

❑ LSVT LOUD (ST only)

❑ VitalStim (ST only)

Frequency: ___ - ___ times a week for ____ - ___ weeks.

Special Instructions / Precautions

_____

_____

I hereby certify that the above services are medically necessary and are approved by me.

Physician's Signature _____ Date: _____

Any patient demographics and insurance information would be greatly appreciated.

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