ELECTRA
REHAB & FITNESS

PLEASE FAX TO (940) 495-2301

PATIENT INFORMATION

Referral Date**:** _____

Patient Name: _____ DOB: _____Age: _____

Phone Number: _____ Alternate Phone Number: _____

Medical Diagnosis/ICD-10: _____ Onset Date/Date of surgery: _____

REFERRAL FOR

- ○ Physical Therapy
- ○ Occupational Therapy
- ○ Speech Therapy
- ○ Cardiac Rehab
- ○ Pulmonary Rehab/ Respiratory Services

PRECAUTIONS/SPECIFIC INSTRUCTIONS: _____

_____

_____

Frequency and duration determined by therapist's recommendations based on assessment and patient considerations. For provider recommendations, please specify _____

HEALTHCARE PROVIDER INFORMATION:

I certify that this patient is under my care and the above rehabilitation is medically necessary and in accordance with a plan established by me.

Ordering physician name:_____ NPI: _____

SIGNATURE (required): _____

PRINTED PROVIDER NAME: _____

1207 S. Bailey St
Electra, TX 76360

www.electrahospital .com

Phone (940) 495-3981
Fax (940) 495-2301