



PLEASE FAX TO (940) 298-1640

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**PATIENT INFORMATION**

Referral Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Alternate Phone Number: \_\_\_\_\_  
Medical Diagnosis/ICD-10: \_\_\_\_\_ Onset Date/Date of surgery: \_\_\_\_\_

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**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:** \_\_\_\_\_