THERAPY TREATMENT REFERRAL

ADDRESS/FACILITY
NAME OF SENDER
ADDRESS LINE 1
ADDRESS LINE 2

SOURCE

☐ PCP ☐ HOSPITAL ☐ SNF ☐ SPECIALIST ☐ ALF ☐ OTHER__________

PATIENT INFO (OPTIONAL IF ATTACHING FACE SHEET)

NAME: ______________________ SS #:______________ DATE: ______________
PHONE: ______________________ D.O.B.: ______________________
ADDRESS: ______________________ CONTACT #: ______________
P.O.A. (IF APPLICABLE): ______________________ P.O.A. CONTACT #: ______________
MEDICARE/PRIMARY INSURANCE #: ______________________
SECONDARY INSURANCE/POLICY #: ______________________

IF POST-ACUTE FOLLOW-UP, EXPECTED DATE OF DISCHARGE:

DIAGNOSIS / REASON FOR REFERRAL / ADDITIONAL NOTES

DISCIPLINE TO EVALUATE & TREAT

☐ PT/OT ☐ SLP SPEECH - LANGUAGE PATHOLOGY ☐ OT OCCUPATIONAL THERAPY ☐ PT PHYSICAL THERAPY

EVALUATE & TREAT AS INDICATED

- ☐ Treatment of Swallowing Dysfunction/ Oral Function
- ☐ Treatment of Speech, Voice, and Language Deficits
- ☐ Cognitive Skills Development
- ☐ Caregiver Education
- ☐ Dementia Management/Caregiver Training
- ☐ ADL Training/Safety
- ☐ Home Safety Assessment
- ☐ Upper Extremity Prosthetic or Orthotic Fitting and Training
- ☐ Therapeutic Exercise
- ☐ Balance Training
- ☐ Therapeutic Activity
- ☐ Coordination Propioception Training
- ☐ Transfer Training
- ☐ Range of Motion
- ☐ Manual Therapy/Massage
- ☐ Pain Management
- ☐ Wheelchair Provision/Training
- ☐ Lower Extremity Prosthetic or Orthotic Fitting and Training
- ☐ Provision of Assistive Device i.e. cane, walker
- ☐ Postural Training
- ☐ Gait/Endurance Training
- ☐ **Other:** ______________________

PHYSICIAN / NP/ PA

PRINT OR STAMP NAME: ______________________ NPI #: ______________
ADDRESS: ______________________ PHONE: ______________
SIGNATURE: ______________________ DATE: ______________

☐ EVAL/TREAT AFTER:
SNF/HOME HEALTH PROVIDER: ______________________ PHONE: ______________

PHYSICAL, OCCUPATIONAL & SPEECH THERAPY

T 916.209.0235 | **W** www.valleyrehab.org

PLEASE FAX TO 1.916.218.6319 OR EMAIL TO INTAKE@VALLEYREHAB.ORG