

Physical/Occupational Therapy Referral Form

Please fax this referral form to the requested location using the fax number listed below. We will contact the patient to schedule an appointment. After the evaluation is completed, a Plan of Care will be faxed to your office for signature and approval. Thank you for your referral!

Patient Name: _____ Date of birth: _____
Patient Address: _____ Patient Phone #: _____
Referring Physician: _____ Physician Phone #: _____
Physician Address: _____

Please have the referring physician complete this section. Please check the following:

Medical Diagnosis: _____

Treatment Plan: ☐ PT/OT ☐ Eval/Treat

Frequency of visits (Times/Week): ☐ 1, ☐ 2, ☐ 3, ☐ 4, ☐ 5

Duration (Weeks): ☐ 1 wk, ☐ 2 wks, ☐ 3 wks, ☐ 4 wks, ☐ 5 wks, ☐ 6 wks, ☐ 8 wks

Treatment (If specified):

- | | |
|---|---|
| ☐ Physical Therapy | ☐ Occupational Therapy/CHT |
| ☐ Strength & Conditioning | ☐ Custom Splinting/Orthotics |
| ☐ Manual Therapy | |
| ☐ Dry Needling | |
| ☐ Balance & Fall Prevention Training | |
| ☐ Modalities | |

Comments/Restrictions/Instructions: _____

I certify that this treatment is medically necessary:

Physician Signature

Date

Preferred Clinic: ☐ **Florence Clinic**
1751 Veterans Drive, Suite 300
Florence, AL 35630
Phone: 256-764-9304
Fax: 256-764-9343

☐ **Muscle Shoals Clinic**
104 Physicians Drive
Muscle Shoals, AL 35661
Phone: 256-246-3490
Fax: 256-764-9343