THERAPY TREATMENT REFERRAL/PRESCRIPTION

FIT AT HOME
PHYSICAL THERAPY & REHABILITATION

F : 848.800.4616 T:848.200.6729

PATIENT INFO (OPTIONAL IF ATTACHING FACE SHEET)

PATIENT NAME:____ DATE: _____________
PATIENT ADDRESS:____
PATIENT PHONE:________________________________ PATIENT D.O.B.:______________
P.O.A. NAME/CONTACT #/ADDRESS: ____
MEDICARE/PRIMARY INSURANCE #:____________________ IF POST-ACUTE FOLLOW-UP, EXPECTED DATE OF DISCHARGE:______________
SECONDARY INSURANCE/POLICY #:____________________

EVALUTE & TREAT INDICATED

Traumatic Brain Injury Program
☐ OT ☐ PT ☐ SLP
Stroke Program
☐ OT ☐ PT ☐ SLP
Fall Prevention Program
☐ OT ☐ PT ☐ SLP
☐ Prosthetic/Orthotic Clinic
☐ Advanced IADL
☐ Hand Therapy
☐ Lymphedema Program

☐ Occupational Therapy (OT) Evaluation/Treatment
☐ Physical Therapy (PT) Evaluation/Treatment
☐ Speech/Language Pathology (SLP) Evaluation/Treatment
☐ Wheelchair & Seating Clinic
☐ Balance Rehabilitation Program
☐ Functional Capacity Evaluation (F.C.E.)
☐ Videofluoroscopic Swallow Study/Modified Barium Swallow

PHYSICIAN/NP/PA

PROVIDER NAME OR PRINTSTAMP:___________________________ NPI: _______________
ADDRESS:____
PHONE:___________________ FAX:_____________
SIGNATURE: _____________________________________ DATE : ________________

SPECIAL INSTRUCTION

PLEASE FAX TO 1.848.800.4616 OR EMAIL THERAPY@FITATHOMEREHAB.COM