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**Rehab Resource, Inc.**  
PHYSICAL & OCCUPATIONAL THERAPY REFERRAL

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_

FREQUENCY OF TREATMENT: \_\_\_\_\_ times/week for \_\_\_\_\_ weeks.

THERAPY TREATMENT REQUESTED:

**MODALITIES**

**DME'S**

- Evaluation and Treat as Indicated
- TENS Evaluation & set-up
- EMG - NCV
- Work Hardening
- Isonkinetic Testing
- Functional Capacity Evaluation
- Back/Neck School
- Cumulative Trauma Program

- Modalities as Indicated
- Whirlpool
- Parafin Bath
- Iontophoresis
- Jobst Compression
- Hot Packs
- Anodyne
- Ultrasound
- Electric Stimulation
- Cervical Traction
- CPM
- Phonophoresis
- Cold Packs

- Brace
- Splint Fabrication
- Fitted Back Brace
- Orthotic-Custom
- Crutches
- Other-Specify Below

**EXERCISE**

- Return to Work Program
- Strength
- Range of Motion
- HOME PROGRAM ONLY
- Return to Sports Program
- Lumbar Stabilization
- Back Extension/Flexion
- Aquatic
- Isokinetic

**GAIT TRAINING**  
WEIGHT BEARING  
INSTRUCTIONS

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Living with Alzheimer's Disease
- Arthritis
- Autism
- Carpal Tunnel Syndrome
- Fibromyalgia
- Heart Problems
- Hip Replacement
- Hyperactivity
- Intervention for Tendon Injuries
- Living with Spinal Cord Injury
- Managing Chronic Pain
- Overcoming Drug and Alcohol Abuse
- Traumatic Brain Injury (TBI)
- Living with Parkinson's Disease

OTHER \_\_\_\_\_

I certify that the treatment is medically necessary and will be reviewed every 30 days.

REFERRING PHYSICIAN SIGNATURE \_\_\_\_\_ Phone \_\_\_\_\_