Bear Creek Rehab

Outpatient Therapy Referral Form

Brooklyn Community Estate

Patient Name: ________________________________ Phone No. _________________________ DOB: _______________

Diagnosis: ____

Insurance Info: Medicare: _______________ Medicaid: _______________ Other Ins: _______________________________

Physician Name: ______________________________________ Phone No. ____________________________________

☐ PT - Eval & Treat	☐ OT - Eval & Treat	☐ SLP – Eval & Treat	Special Programs
☐ Therapeutic Exercise	☐ ADL Retraining	☐ Cognitive Therapy	☐ Arthritis Program
☐ Gait Training		☐ Oral Motor Therapy	☐ Rehab Program
☐ Balance Training	Upper Extremity	☐ Dysphagia Therapy	☐ Cardiopulmonary
☐ Fall prevention	☐ Strengthening	☐ Other _______________	☐ Lumbago/Cervical Pain
☐ LE Edema Reduction	☐ Stretching	______________________	☐ Lymphedema Management
☐ Manual Therapy	☐ ROM: _______________		☐ Incontinence/Bladder Retraining
☐ TENS	☐ UE Edema Reduction		☐ Other _______________
☐ Ultrasound			______________________
☐ ESTIM	☐ Other _______________		
☐ Other _______________	______________________		
______________________			

Frequency: ☐ As Indicated ☐ Daily ☐ 2x/wk ☐ 3x/wk ☐ 5x/wk ☐ Other: ______________________________

Duration: ☐ As Needed ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ 1 month ☐ Other: __________________________

Comments/Parameters:____

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Physician Signature: ____ Date: ________/______/__________

Contact: Charge Nurse with orders. 406 North Street, Brooklyn, Iowa 52211 (**Phone)** 641-522-9263 **(Fax)** 641-522-5684