MAXIMUM REHAB CENTER
Physical & Occupational Therapy

PHYSICIAN REFERRAL

From:_____ FAX#_____

- **Appointment is scheduled for** (leave blank, we will contact you with this info)

DATE: _____ TIME:_____

PATIENT NAME:_____ DATE OF BIRTH:_____

PATIENT PHONE #: _____

DIAGNOSIS:_____ ICD 9' CODE:_____

SURGERY PERFORMED:_____ DATE OF SURGERY:_____

PLAN OF CARE:

Frequency:_____/visits per week Duration:_____/weeks

EVALUATE & TREAT PER PHYSICIAN PLAN OF CARE AS FOLLOWS

- ◯ PHYSICAL THERAPY
- ◯ OCCUPATIONAL THERAPY

STANDARD TREATMENT PLAN

- ☐ THERAPEUTIC EXERCISE
- ☐ GRASTON TECHNIQUE
- ☐ ELECTRICAL STIMULATION
- ☐ ULTRASOUND
- ☐ HOME EXERCISE PROGRAM
- ☐ IONTOPHORESIS
- ☐ HEAT/MOIST HOT PACK
- ☐ TENS
- ☐ TRACTION TABLE

OTHER:_____

PHYSICIAN SIGNATURE:_____ DATE: _____

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