Outpatient Therapy Referral

NMC health®

PO Box 308 | Newton, KS 67114

DATE _____

PATIENT NAME _____

DOB _____ PHONE NUMBER _____

DIAGNOSIS _____ ICD-10 CODE(S) _____

PLEASE SPECIFY TYPE OF TREATMENT:

☐ PHYSICAL THERAPY ☐ OCCUPATIONAL THERAPY

PRECAUTIONS _____

GOALS _____

☐ TREAT _____ TIMES A WEEK FOR _____ WEEKS OR _____ VISITS
☐ EVALUATION AND TREATMENT TO BE DEVELOPED BY THE PHYSICAL THERAPIST
☐ EVALUATION AND TREATMENT TO BE DEVELOPED BY THE OCCUPATIONAL THERAPIST

☐ ASTYM/SOFT TISSUE MOBILIZATION
☐ ATHLETIC INJURY PREVENTION PROGRAM
☐ AQUATIC THERAPY
☐ BALANCE/GAIT TRAINING
☐ CONCUSSION MANAGEMENT
☐ CUSTOM SPLINT
☐ DRY NEEDLING
☐ ELECTRICAL STIMULATION
☐ HOME EXERCISE PROGRAM
☐ IONTOPHORESIS (please give the patient a separate prescription for 30ml of 4mg/ml Dexamethasone)
☐ LYMPHEDEMA
☐ MANUAL THERAPY
☐ MECHANICAL TRACTION
☐ NEUROMUSCULAR RE-EDUCATION
☐ OSTEOPOROSIS PROGRAM
☐ PARAFFIN BATH
☐ PRE/POSTPARTUM EXERCISE PROGRAM
☐ THERAPEUTIC EXERCISE
☐ TMJ PROGRAM
☐ ULTRASOUND

PHYSICIAN SPECIFIC ORDERS: _____

_____

_____

X_____ **DATE/TIME:** _____

PHYSICIAN SIGNATURE

Patient Label