Innovative Swallowing & Therapeutics LLC
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Physician Referral Form

Client Information

Name: ____

Date of Birth: ____________ Age: _______ Gender: ________

Address: ____

Preferred Phone: ________________ Okay to Leave Message: Y / N

Secondary Phone: ________________ Okay to Leave Message: Y / N

Physician Name:____

Address: ____

Physician Phone Number: ________________ Fax Number: ________________

Primary Medical Diagnosis: ______________________________________

ICD-10 Code(s): (1) ______________ **(2)**______________ **(3)** ____________

Reason for Referral: ______________________________________

____

Occupational Therapy
□Evaluate & Treat

Range of Motion □
Decreased Strength □
Transfers □
Scar Tissue Management □
Wheelchair Evaluation □

Self-Care □
Feeding □
Falls □
CustomSplinting □
Positioning/Posture □
Low Vision □

Speech Therapy
□Evaluate & Treat

Swallowing □
Language □
Speech Intelligibility □
Cognition □
Voice □
Safety Awareness □

Other:

Frequency of Treatment: □ **As Needed** □ **Two times a week** □ **Three times a week**

Duration: ____________ **weeks**

My signature on this form authorizes this treatment as Medically Necessary:

______________________________ ______________

Physician Signature **Date**