Body & Soul MFR Therapy

OUTPATIENT OCCUPATIONAL THERAPY PHYSICIAN'S REFERRAL FORM

Name		**DOB**		**Age**		**Gender**	
Address		**Zip**		**City/State**			
Phone		**Status**		**Occupation**			
Insurance		**SSN** last 4#		**Email**			
Auth/Claim#		**Private**		**WComp**		**MVA**	
Physician's Name				**Physician's Phone#**			
NPI #				**Fax#**			

MEDICAL DIAGNOSIS: ____

- ⬜ OT to Evaluate & Treat, as Indicated.
- ⬜ Myofascial Release (MFR) treatment / Manual Therapy
- ⬜ Therapeutic Exercise (Strengthening, Flexibility, Range of Motion)
- ⬜ Therapeutic Activity / Neuromuscular Re-Education (Balance, Motor Control, ADL)
- ⬜ Home Exercise Program (HEP) / Patient Education
- ⬜ Women's / Men's Health for Pelvic Floor / Sacral / Coccygeal Pain & Restrictions
- ⬜ Continue OT

FREQUENCY per WEEK: ___________ DURATION: _____________ THERAPIST DISCRETION: __________

All clinical information has been reviewed by an attending Physician. Skilled Occupational Therapy intervention is medically necessary at this time.
Plan of care has been reviewed and discussed with patient. Patient in agreement with the recommendation.

PHYSICIAN' SIGNATURE: ________________________________ DATE: _________________

PHYSICIAN NAME: _______________________________________ TIME: _________________

OCCUPATIONAL THERAPIST SIGNATURE/S:

- ⬜ Kimberly Fitzgerald, OTR (Lic.# 4507-026) NPI: 1972717460 Phone: 920-209-0012 Fax: 920-888-2409
- ⬜ Yvonne Vander Heiden, COTA (Lic. # 5161-27) NPI: 1316316730 Phone: 920-209-0012 Fax: 920-888-2409