

# ☐ Physical      ☐ Occupational      Therapy Referral

<b>Patient Information:</b>	
Patient Name:	
DOB:	
Phone:	
Insurance: (Primary)	
(Secondary)	

<b>Location of Therapy:</b>
<input type="checkbox"/> Omni Rehab, Dunlap Phone: (423) 949-7899 Fax: (423) 949-3416
<input type="checkbox"/> Erlanger Bledsoe, Pikeville Phone: (423) 447-5360 Fax: (423) 447-3154
<input type="checkbox"/> Omni Rehab @ Bryan College, Dayton Phone: (423) 775-7101 Fax: (423) 775-7103

<b>Diagnosis Code:</b>			
	<b>Unspecified</b>	<b>Right</b>	<b>Left</b>
Abnormality of Gait	<input type="checkbox"/> R26.9		
Adhesive Capsulitis of Shoulder	<input type="checkbox"/> M75.00	<input type="checkbox"/> M75.01	<input type="checkbox"/> M75.02
Debility	<input type="checkbox"/> R53.81		
Fatigue	<input type="checkbox"/> R53.83		
Lack of Coordination	<input type="checkbox"/> R27.9		
Malaise	<input type="checkbox"/> R53.81		
Muscular Wasting/Disuse Atrophy	<input type="checkbox"/> M62.50		
Muscle Weakness	<input type="checkbox"/> M62.81		
Back Pain	<input type="checkbox"/> M54.5		
Back Pain with Sciatica	<input type="checkbox"/> M54.40	<input type="checkbox"/> M54.41	<input type="checkbox"/> M54.42
Sciatica	<input type="checkbox"/> M54.3		
Thoracic Pain	<input type="checkbox"/> M54.6		
Neck Pain	<input type="checkbox"/> M54.2		
Pain- Ankle/Foot	<input type="checkbox"/> M25.579	<input type="checkbox"/> M25.571	<input type="checkbox"/> M25.572
Pain- Knee	<input type="checkbox"/> M25.569	<input type="checkbox"/> M25.561	<input type="checkbox"/> M25.562
Pain- Hip, Pelvis, Thigh	<input type="checkbox"/> M25.559	<input type="checkbox"/> M25.551	<input type="checkbox"/> M25.552
Pain- Fingers	<input type="checkbox"/> M79.646	<input type="checkbox"/> M79.644	<input type="checkbox"/> M79.645
Pain- Hand	<input type="checkbox"/> M79.646	<input type="checkbox"/> M79.641	<input type="checkbox"/> M79.642
Pain- Wrist	<input type="checkbox"/> M25.539	<input type="checkbox"/> M25.531	<input type="checkbox"/> M25.532
Pain- Forearm	<input type="checkbox"/> M25.539	<input type="checkbox"/> M25.540	<input type="checkbox"/> M25.541
Pain- Elbow	<input type="checkbox"/> M25.529	<input type="checkbox"/> M25.521	<input type="checkbox"/> M25.523
Pain- Upper Arm	<input type="checkbox"/> M79.629	<input type="checkbox"/> M79.621	<input type="checkbox"/> M79.622
Pain- Shoulder	<input type="checkbox"/> M25.519	<input type="checkbox"/> M25.511	<input type="checkbox"/> M25.512
Pain- Multiple Sites	<input type="checkbox"/> M25.50		
Stiffness- Ankle/Foot	<input type="checkbox"/> M25.673	<input type="checkbox"/> M25.674	<input type="checkbox"/> M25.675
Stiffness- Knee	<input type="checkbox"/> M25.669	<input type="checkbox"/> M25.661	<input type="checkbox"/> M25.662
Stiffness- Hip	<input type="checkbox"/> M25.659	<input type="checkbox"/> M25.651	<input type="checkbox"/> M25.652
Stiffness- Hand	<input type="checkbox"/> M25.649	<input type="checkbox"/> M25.641	<input type="checkbox"/> M25.642
Stiffness- Wrist	<input type="checkbox"/> M25.639	<input type="checkbox"/> M25.631	<input type="checkbox"/> M25.632
Stiffness- Elbow	<input type="checkbox"/> M25.629	<input type="checkbox"/> M25.621	<input type="checkbox"/> M25.622
Stiffness- Shoulder	<input type="checkbox"/> M25.619	<input type="checkbox"/> M25.611	<input type="checkbox"/> M25.612
Stiffness- Unspecified	<input type="checkbox"/> M25.60		
	<input type="checkbox"/>		
	<input type="checkbox"/>		

<b>Prescribed Treatment:</b>	
<input type="checkbox"/> Evaluate and Treat <input type="checkbox"/> Therapeutic Exercise (P/AA/AROM, PRE) <input type="checkbox"/> Therapeutic Activities <input type="checkbox"/> ADLs	<input type="checkbox"/> Gait Training <input type="checkbox"/> Manual Techniques <input type="checkbox"/> Ultrasound <input type="checkbox"/> Aquatic Therapy (unable to perform land-based therapy) <input type="checkbox"/> Other _____
Frequency: 1 2 3 4 5 /week	Duration: _____ weeks
Physician Print: _____ Physician Phone: _____	
Physician Signature: _____ Date: _____	
I certify the above marked therapy and/or rehabilitation service is medically necessary.	