OrthoRehab Physical Therapy

PHYSICAL THERAPY REFERRAL / ORDER

8425 Bandera Rd Ste 120, San Antonio, TX 78250 | myorthorehab.com
Phone (210) 307-4924 | Fax (210) 307-4925
referrals@myorthorehab.com

Fax to (210) 307-4925 or email referrals@myorthorehab.com, and we'll call your patient within 1 business day to schedule.

PATIENT

Patient name: _____ Date of birth: _____

Phone: _____ Alternate phone: _____

Payer: ☐ Medicare ☐ Commercial plan / member ID: _____ ☐ Workers' comp ☐ Self-pay

☐ **Personal injury / LOP** Attorney name: _____ Atty phone: _____

Please attach a copy of the insurance card and face sheet. *Most major insurance, personal injury/LOP and self-pay accepted.*

DIAGNOSIS

ICD-10 code(s): _____ Description: _____

Onset / injury date: _____ Surgery date: _____ ☐ **Post-op** (check & specify below)

Surgery: ☐ ACL reconstruction ☐ Rotator cuff repair ☐ Total knee ☐ Total hip ☐ Spinal fusion / lami
☐ Fracture / ORIF ☐ Meniscus / arthroscopy Other: _____

BODY REGION (check all that apply)

☐ Cervical ☐ Thoracic ☐ Lumbar ☐ Shoulder ☐ Elbow ☐ Wrist / hand ☐ Hip ☐ Knee ☐ Ankle / foot

Side: ☐ Left ☐ Right ☐ Bilateral Other region: _____

ORDER

☐ **EVALUATE AND TREAT**

Frequency: ☐ 2x / week ☐ 3x / week Other: _____

Duration: ☐ 4 weeks ☐ 6 weeks ☐ 8 weeks Other: _____

Specific interventions (optional):

☐ Therapeutic exercise ☐ Manual therapy ☐ Neuromuscular re-education ☐ Gait / balance training
☐ Modalities / e-stim ☐ Dry needling ☐ Home exercise program

Weight-bearing: ☐ WBAT ☐ FWB ☐ PWB %: ___ ☐ TTWB ☐ NWB Brace / ROM limits: _____

Precautions / contraindications: _____

Notes: _____

_____

REFERRING PROVIDER

Provider name: _____ **Credentials:** ☐ MD ☐ DO ☐ NP ☐ PA Other: _____

NPI (required for billing): _____ Practice: _____

Office phone: _____ Office fax: _____

Provider signature: _____ Date: _____

Signature required for Medicare and most insurers. Office contact: _____

Thank you for trusting OrthoRehab with your patients.