

Physician Referral - Therapy Services

Please send this script to Bardavon Health Innovations to Fax at **913-826-6508**.

Patient Name: _____ Date: _____

Claim #: _____ Employer: _____

DOB: _____ Phone: _____

Diagnosis: _____ Return to Dr. Date: _____

ICD 10 Code: _____ Work Status: _____

Precautions/Restrictions: _____

Rehabilitation Services: PT/OT

Evaluation/Treatment
Therapeutic Ex./Activity
Aquatic Therapy
Manual Therapy
HEP/Pt. Ed./Self Care
Gait Training
Work Conditioning
FCA/FCE
XRTS Testing
Vestibular Therapy (VRT)
Other: _____

Hand Therapy

Evaluation/Treatment
Therapeutic Ex./Activity
Manual Therapy
HEP/Pt. Ed./Self Care
Custom Splint Fabrication
Specific Protocol
Other: _____

Onsite Therapy

Work Conditioning
Work Station Evaluations
Ergonomic Assessment
Job Analysis
Other: _____

Modalities

Hot/Cold Packs
Electrical Stimulation
Ultrasound
Iontophoresis
TENS/Home Use Instructions

Goals/Other: _____

Frequency: _____ Time(s) per week

Duration: _____ Week (s)

Physician's Signature: _____ Date: _____

Print Name: _____ Phone: _____

Care Team

Adjuster: _____

Phone: _____ Fax: _____