BARDAVON®
Health Innovations

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Physician Referral - Therapy Services

*Please fax this script to Bardavon Health Innovations at **913-236-3559** or email it to **referrals@bardavon.com**.*

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: ______________________

Therapy Clinic: ______________________

Phone: ______________________ Fax: ______________________

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