THERAPY REFERRAL

_____TWIN FALLS CLINIC 254 River Vista Place

_____BURLEY CLINIC 224 E Main, Burley

PATIENT NAME: ________________________________ **DATE OF BIRTH:** __________

Contact Name & Phone Number: ________________________________

REFERRAL DATE / START OF CARE : ______________

DIAGNOSIS: ____

______ **CHRONIC CONDITION** ______ **ACUTE CONDITION**

______ **PHYSICAL THERAPY EXAMINATION AND TREATMENT**
______ **OCCUPATIONAL THERAPY EXAMINATION AND TREATMENT**
______ **SPEECH THERAPY EXAMINATION AND TREATMENT**

FREQUENCY: ____________________ **DURATION:**________ **weeks**

TYPES OF SERVICES NEEDED/ANTICIPATED OUTCOMES:

PHYSICIAN NAME (print) ____

PHYSICIAN SIGNATURE: ____

Twin Falls office: phone # 208-734-7333 fax 208-734-8350
Burley office: phone # 208-647-0184 fax 208-647-0222

REFERRAL FOR SPECIALTY SERVICES *(please circle)*

PHYSICAL THERAPY

TORTICOLLIS/PLAGIOCEPHALY
VESTIBULAR REHABILITATION
ORTHOPEDIC ASSESSMENT
LYMPHEDEMA MANAGEMENT
CONCUSSION MANAGEMENT
HEADACHE
GRASTON
BURN/WOUND

OCCUPATIONAL THERAPY

TORTICOLLIS/PLAGIOCEPHALY
SENSORY CONCERNS
FINE MOTOR SKILLS
SENSORY INTEGRATION & PRAXIS TESTING
INCONTINENCE EVALUATION / TREATMENT

SPEECH THERAPY

VITAL STIM
BILINGUAL
ORAL-MOTOR EVALUATION
AUGMENTATIVE COMMUNICATION ASSESSMENT
APRAXIA
ARTICULATION