PHYSICAL THERAPY/OCCUPATIONAL REFERRAL FORM

Phone: 813-957-5885 Fax: 813-563-6358

FOCUS REHAB
MOBILE PHYSICAL THERAPY & WELLNESS

Home Health : ☐ PT ☐ OT

Patient's Name: DOB: Date:

Patient's Contact Number: _____

Physician's Name: _____

Physician's Contact Number: _____

Diagnosis: _____

Physical Therapy/Occupational Therapy Treatment

- ☐ Evaluation and Treatment
- ☐ Orthopedic Rehabilitation
- ☐ Pre & Post-Surgical Therapy
- ☐ Therapeutic Exercises
- ☐ PROM / AAROM / AROM
- ☐ Neuromuscular Re-Ed
- ☐ Gait Analysis/Training
- ☐ Manual Joint Mobilization
- ☐ Spine Rehabilitation
- ☐ Other

Specialty Services

- ☐ Cardio/Pulmonary Rehab
- ☐ Parkinson's Wellness Recovery (PWR!)
- ☐ Vestibular/ Balance Therapy
- ☐ Fall Prevention Therapy
- ☐ Home Safety Assessment
- ☐ Neuro/ Post Stroke Therapy

Notes

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I hereby certify these services as medically necessary for the patient's plan of care.

Physician's Signature:_____ Date: _____