REHABILITATIVE SERVICES REFERRAL

☐ **Center for Rehabilitation**
3190 E. Midland Road
Bay City, MI 48706
Ph: (989) 667-6600

☐ **Pinconning Physical Therapy**
4293 N. Huron Rd. (M-13), Ste. 2
Pinconning, MI 48650
Ph: (989) 667-6600

☐ **West Side Medical Mall (PT Only)**
4175 Euclid Ave., Ste. 6
Bay City, MI 48706
Ph: (989) 667-6600

☐ **West Branch Rehab Svs**
2110 South M-76, Ste. 2
West Branch, MI 48661-8737
Ph: (989) 667-6600

Please fax referrals for any location to (989) 667-6610

Patient: ______________________ D.O.B.: ______________

Onset Date: ______________ Patient Phone Number: ______________________

Diagnosis: ______________________ Diagnosis Code: ______________________

Precautions: ______________________ Duration & Frequency: ______________________

☐ **Physical Therapy** (Eval & Treat)

☐ **Occupational Therapy** (Eval & Treat)

☐ **Speech - Language Pathology** (Eval & Treat)

Evaluate, develop and implement plan of care per protocol

MODALITIES
- ☐ Paraffin Bath
- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ TENS
- ☐ Traction
  - ☐ Cervical ☐ Lumbar
- ☐ Iontophoresis
- ☐ Phonophoresis

SPLINTING
- ☐ Dynamic
- ☐ Static

WOMENS/MENS HEALTH
(CFR and West Branch Only)
- ☐ Urinary Incontinence
- ☐ Pelvic Pain

WORK PERFORMANCE
- ☐ Functional Capacity Eval
- ☐ Work Conditioning
- ☐ Work Hardening

THERAPEUTIC EXERCISE PROGRAMS
- ☐ ROM / Stretching / A / AA / PROM
- ☐ Strengthening Exercises
- ☐ Back Education Programs
- ☐ Isokinetics
- ☐ Home Educational Program
- ☐ Spine Stabilization
- ☐ Gait Training
- ☐ Post Surgical ______________

SPEECH THERAPY
- ☐ Swallowing
- ☐ Videofluoroscopy Evaluation
- ☐ Voice Retraining
- ☐ Cognition
- ☐ NMES for Swallowing
- ☐ Speech / Language
- ☐ Other ______________

OTHER
- ☐ Spine Program
- ☐ Low Vision
- ☐ LSVT (Lee Silverman BIG/LOUD)
- ☐ Wheelchair/mobility eval
- ☐ Pediatric Eval & Treatment

MANUAL THERAPY
- ☐ Soft Tissue Mobilization
- ☐ Joint Mobilization

VESTIBULAR
- ☐ Vertigo
- ☐ Difficulty Walking
- ☐ Dizziness
- ☐ Balance Evaluation & TX

LYMPHEDEMA
(West Branch Only)
- ☐ Edema
- ☐ Mastectomy/Lumpectomy
- ☐ Lymph Node Removal
- ☐ Venous Stasis Insufficiency

CANCER REHABILITATION
- ☐ Lymphedema
- ☐ Cancer Rehabilitation

MEDICARE PHYSICIANS CERTIFICATION/RECERTIFICATION STATEMENT
I certify/recertify the need for rehabilitation every 30 days, according to Plan of Care, which was reviewed by me. The patient is under my active care.

Physician's Printed Full Name: ______________________________

Physician's Signature: ______________________ Date: ______________

REHABILITATIVE SERVICES REFERRAL

ADDRESSOGRAPH

BAY-029 (9.24)