



**PRIMARY THERAPY SOURCE**

**PHYSICAL • OCCUPATIONAL • SPEECH THERAPY**

**THERAPY REFERRAL**

Patient Name: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

\_\_\_\_\_ Physical Therapy Exam & Treatment

\_\_\_\_\_ Occupational Therapy Exam & Treatment

\_\_\_\_\_ Speech Therapy Exam & Treatment

Frequency: \_\_\_\_\_ x week      Duration: \_\_\_\_\_ weeks

Remarks:

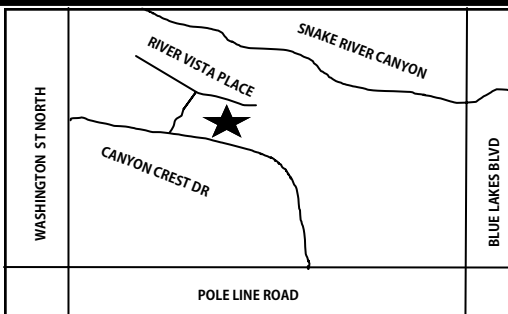
Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_      Physician Office Phone: \_\_\_\_\_

- \*Adaptive Equipment Assessments
- \*Aquatic Physical Therapy
- \*Back, Headache & Neck Pain Care
- \*Balance & Coordination Training
- \*Cardiopulmonary Endurance Training
- \*Ergonomic Assessment
- \*Fitness Assessment
- \*Gait Training
- \*Infant Behavioral Assessments
- \*Infant Developmental Assessments
- \*Lymphedema Management
- \*Massage & Soft Tissue Mobilization
- \*Neurologic & Orthopedic Evaluations
- \*Occupational Therapy
- \*Orthotic & Prosthetic Training
- \*Orthopedic Rehabilitation
- \*Pain Management
- \*Pediatric Burn Care
- \*Pediatric Communication Assessments
- \*Pediatric Evaluation & Treatments
- \*Pediatric Motor Development Training
- \*Pre-Natal Back Pain Management
- \*Post-Mastectomy Rehabilitation
- \*Post-Operative Care
- \*Speech & Language Therapy
- \*Spinal Stabilization & Strengthening
- \*Sports Injury Rehabilitation

**FAX REFERRAL TO: 208-734-8350**

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