UF Health Jacksonville Rehabilitation Services
OUTPATIENT REFERRAL FORM

DATE ____________________________

NAME ___________________________________________  DOB ___________ UNIT NO _____________

DIAGNOSIS ___________________________________________  ICD 9 DX CODE ___________ AREA TO TREAT __________________

ONSET OF CURRENT CONDITION __________________CONTRAINDICATIONS/PRECAUTIONS __________________

INSURANCE __________________  AUTH # __________________  NO. OF VISITS ________ EXP DATE ___________

CHECK EVALUATE AND TREAT OR CHOOSE SPECIALTY BY CHECKING LIST BELOW
(Medicare orders must be signed by the attending physician or non-physician practitioner only)

____ PHYSICAL THERAPY EVALUATE AND TREAT AS INDICATED
___ Vestibular/Balance Training*  ___ Lymphedema Mgt for Upper Extremity/Head and Neck*
___ Neuro Rehab*  ___ Pulmonary Management*
___ Ortho/Post-Op Rehab  ___ Women’s Health/Pelvic Rehab/Continence Therapy*
   Surgery date __________________________ Protocol __________________________

____ OCCUPATIONAL THERAPY EVALUATE AND TREAT AS INDICATED
___ Hand/Upper Extremity Rehab  ___ Motor/Manual Wheelchair Evaluation & Training*
___ Orthosis  ___ Seating and Positioning Evaluation & Training*
   Type needed____________________________

____ SPEECH THERAPY EVALUATE AND TREAT AS INDICATED*
___ Speech, language and communication therapy*  ___ Modified Barium Swallow Study*
___ Cognitive Therapy*  ___ Swallow Therapy*

*(Service available at Pavilion facility only)

SPECIAL INSTRUCTIONS:________________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

I certify that I have examined the patient and determined that outpatient therapy is medically necessary.

_______________________________________________________________________________________

PHYSICIAN NAME IN PRINT

_______________________________________________________________________________________

PHYSICIAN SIGNATURE AND ID #

_______________________________________________________________________________________

REFERRAL COORDINATOR NAME AND PHONE/FAX #