UF Health Jacksonville Rehabilitation Services
OUTPATIENT REFERRAL FORM

☐ UF Health Rehab - NORTH
15255 Max Leggett Parkway
Suite 4100
Jacksonville, FL 32218
Tel # 904-427-1179
Fax # 904-427-1180

☐ UF Health Rehab - EMERSON
4555 Emerson St. Expressway
Suite 115
Jacksonville FL 32207
Tel # 904-633-0090
Fax # 904-633-0091

☐ UF Health Rehab - JACKSONVILLE
555 W 8th Street, 1st floor
Jacksonville FL 32209
Tel # 904-244-1179
Fax # 904-244-1180

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*
__ Neuro Rehab*
__ Ortho/Post-Op Rehab
Surgery date _____
Protocol _____
__ Lymphedema Mgt for Upper Extremity/Head and Neck*
__ Pulmonary Management*
__ Women's Health/Pelvic Rehab/Continence Therapy*
__ TMJ/ Craniofacial Rehab

____ OCCUPATIONAL THERAPY EVALUATE AND TREAT AS INDICATED

__ Hand/Upper Extremity Rehab
__ Orthosis
Type needed_____
__ Motor/Manual Wheelchair Evaluation & Training*
__ Seating and Positioning Evaluation & Training*

____ SPEECH THERAPY EVALUATE AND TREAT AS INDICATED*

__ Speech, language and communication therapy*
__ Cognitive Therapy*
__ Modified Barium Swallow Study*
__ Swallow Therapy*

*(Service available at Pavilion facility only)

SPECIALINSTRUCTIONS:_____

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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 #