UFHealth
UNIVERSITY OF FLORIDA HEALTH

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
4549 Emerson St.
Suite 300
Jacksonville FL 32207
Tel # 904-427-8900
Fax # 904-427-8901

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

DATE _____

PATIENT NAME _____DOB_____

DIAGNOSIS_____ICD 10 DX CODE(s)_____

DATE OF ONSET OF CURRENT CONDITION _____

CONTRAINDICATIONS/PRECAUTIONS_____

INSURANCE_____AUTH #_____NO. OF VISITS_____EXP DATE_____

PLEASE CHOOSE EVALUATE AND TREAT and SPECIALTY THERAPY TYPE, as indicated
(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

Other INSTRUCTIONS:_____

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

_____
PHYSICIAN NAME IN PRINT

_____
PHYSICIAN SIGNATURE AND ID #

_____
REFERRAL COORDINATOR NAME AND PHONE/FAX #