KEKA REHAB SERVICES REFERRAL FORM

FACILITY/RESIDENCE

SOURCE

☐ PCP ☐ HOSPITAL ☐ SNF ☐ SPECIALIST ☐ SELF ☐ ADH

PATIENT INFO (OPTIONAL IF ATTACHING FACE SHEET)

PATIENT NAME: ______________________ DATE: __________

PATIENT ADDRESS: ______________________

PATIENT PHONE: ______________________ PATIENT D.O.B.: __________

P.O.A. NAME/CONTACT #/ADDRESS: ______________________

PHYSICIAN NAME: ______________________ PHYSICIAN PHONE: __________

MEDICARE/PRIMARY INSURANCE #: ______________________

SECONDARY INSURANCE/POLICY #: ______________________

IF POST-ACUTE FOLLOW-UP, EXPECTED DATE OF DISCHARGE:

DIAGNOSIS / REASON FOR REFERRAL / ADDITIONAL NOTES

DISCIPLINE TO EVALUATE & TREAT

☐ PT/OT ☐ SLP SPEECH-LANGUAGE PATHOLOGY ☐ OT OCCUPATIONAL THERAPY ☐ PT PHYSICAL THERAPY

EVALUATE & TREAT AS INDICATED

☐ Treatment of Swallowing Dysfunction / Oral Function
☐ Treatment of Speech, Voice, and Language Deficits
☐ Cognitive Skills Development
☐ Caregiver Education
☐ Dementia Management / Caregiver Training
☐ ADL Training / Safety
☐ Home Safety Assessment

☐ Therapeutic Exercise
☐ Balance Training
☐ Therapeutic Activity
☐ Coordination Proprioception Training
☐ Transfer Training
☐ Range of Motion

☐ Manual Therapy / Massage
☐ Pain Management
☐ Wheelchair Provision / Training
☐ Provision of Assistive Device i.e. cane, walker
☐ Postural Training
☐ Gait / Endurance Training

☐ OTHER: ______________________

CONSENT

VERBAL CONSENT OBTAINED? YES ☐ NO ☐

PERSON GIVING CONSENT: ______________________

DAYS OF ATTENDANCE: M ☐ T ☐ W ☐ TH ☐ M ☐

FACILITY

PRINT OR STAMP NAME: ______________________ FAX: __________

ADDRESS: ______________________ PHONE: __________

SIGNATURE: ______________________ DATE: __________

☐ EVAL / TREAT AFTER:

SNF / HOME HEALTH PROVIDER: ______________________ PHONE: __________

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PHYSICAL, OCCUPATIONAL, & SPEECH THERAPY.
EXCELLENCE IN THERAPY SERVICES.

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