COFFEE REGIONAL MEDICAL CENTER

REFERRAL FOR REHABILITATION SERVICES

100 Doctor's Drive, Suite 105
P.O. Box 1287
Douglas, GA 31534
Phone: (912) 383−5645 Fax: (912) 383−5677

1PT

Physician Offices−
For the most updated form please visit
www.coffeeregional.org and
print from the "For Our Physicians" link.

Date:_____

PATIENT NAME _____

DIAGNOSIS with ICD 10 _____

PRECAUTIONS/SPECIAL INSTRUCTIONS _____

_____

_____ **EVALUATE AND TREAT**

_____ **EVALUATE ONLY**

Please Select Specialty

PHYSICAL THERAPY **OCCUPATIONAL THERAPY**

MODALITIES

___ Hot Pack/ Cold Pack
___ Whirlpool
___ Electrical Stimulation
___ Ultrasound
___ Phonophoresis
___ Inontophoresis
___ Traction
___ Fluidotherapy
___ Cold Compression
___ Other

EXERCISE PROGRAMS

___ Gait Traning
___ Balance/Vestibular Training
___ CVA Rehab
___Hand/ Wrist/Elbow Rehab
___ Home Exercise Program
___Upper Extremity Coordination Train
___ Work Hardening
___ Work Conditioning
___ Biofeedback
___ Pediatric Services
___ Therapeutic Exercise
___ Other

PROCEDURES

___ Isokinetic Testing
___ Isokinetic Exercise
___ Joint Mobilization
___ Massage
___ Functional Capacity Eval
___ Impairment Rating Data
___ Splinting
___ Orthotic Training
___ Prosthetic Training
___ Pediatric Assessment
___ Body Mechanic Training
___ Fall Risk Screen
___Pelvic Floor
___Dry Needling
___ Other

FREQUENCY OF TREATMENT:

_____ **AS NEEDED**

_____ **TIMES PER WEEK FOR** _____ **WEEKS**

RETURNS TO PHYSICIAN: _____
(NEXT APPOINTMENT DATE)

_____
PHYSICIAN'S SIGNATURE/ DATE

PT 08/08/18 JK