OUTREACH
Physical and Occupational Therapy and Speech Rehabilitation, PLLC

THERAPY REFERRAL FORM

PLEASE FAX TO 201-604-7194 OR EMAIL TO INTAKE@OUTREACH-REHAB.COM

Patient Information:(Optional if attaching face sheet)

Full Name: _____ DOB: _____
Address: _____
Home Phone: _____ Cell: _____ Email: _____
P.O.A Name / Ph# / Email: _____
Agency/HHA Contact #: _____

Insurance: ☐ Private Pay: ☐
Medicare/ Primary Insurance # _____
Secondary Insurance/Policy #: _____

Diagnosis / Notes (Medical History, Frequency, Duration, Precaution, etc.)

Therapy:

☐ Physical Therapy (PT)
☐ Occupational Therapy (OT)
☐ Speech Language Pathology (SLP)

Referring Physician/NP/PA (or attach your standard Rx):

Name:_____NPI#:_____
Address: _____ Fax #_____
Email: _____Office#_____

I certify these services as medically necessary for the patient's plan care.
Signature: _____ Date: _____

COMMENTS:

O: 212.842.0080
F: 201.604.7194
OUTEACH-REHAB-COM
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NEW YORK NY 10022