Therapy Choice

Patient's Name: _____ **Date:** _____
Address: _____
Phone: _____ **Patient's D.O.B:** _____
Primary Insurance & Member ID: _____
ICD-10-CM: _____

Medical Diagnosis: Please Check Off Reason(s) for Treatment

- ☐ Abnormality of Gait
- ☐ COPD
- ☐ Degenerative Disk Disease
- ☐ Fracture:
- ☐ Muscular Wasting
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ ALS
- ☐ CVA
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Other:

Plan of Care: Kindly Indicate Appropriate Treatments/Modalities

- ☐ Therapeutic Exercise
- ☐ Balance, Postural Training
- ☐ Home Safety Evaluation
- ☐ Transfer Training
- ☐ Community Mobility
- ☐ Wheelchair Eval, Instruction, & Training
- ☐ Joint Mobilizations
- ☐ ADL Training/Safety
- ☐ Gait Training
- ☐ Caregiver Education
- ☐ Cognitive Skills Development
- ☐ Massage
- ☐ Prosthetic Training
- ☐ Orthotic Fitting & Training

☐ **PT/OT** ____ **x/wk** ☐ **PT** ____ **x/wk** ☐ **OT** ____ **x/wk** ☐ **ST** ____ **x/wk**

Print Physician's/NP Name: _____
Physician's/NP NPI#: _____
Physician's/NP Phone: _____
Physician's/NP Fax: _____

Kindly provide recent Medical History documentation with this Referral

Physician's Signature: _____ Date: _____

Please Fax Referral Form to: 215.743.8750

10501 Academy Rd, Suite N, Philadelphia, PA 19114 **p:** 215-743-1060 therapy**choice**.com