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**Referral and Prescribing Orders**

Patient’s Name: DOB: Date: Patient’s Contact Number: Physician’s Name: Diagnosis: Medical Precautions:   
Agency Requesting Referral:

* **Physical Therapy Evaluation and Treatment**
* **Occupational Therapy Evaluation and Treatment**



**Physical & Occupational Therapy Referral Form**

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| --- |
| **Requested Interventions & Modalities** |

* Aquatic Therapy □ Fall Prevention / Fall Recovery Training
* Neuromuscular Re-education □ Balance Training / Vestibular Treatment
* ADL & IADL Training / Adaptive Equipment Training □ Spine Treatment / Spinal Decompression
* Gait Analysis / Training □ Therapeutic (Kinesiology) Taping
* Low Level Light Laser (Class IV Cold Laser) □ Post-Surgical Treatment
* Neurological Electrical Stimulation (Neubie Device) □ Posture / Ergonomics / Body Mechanics
* Manual Therapy / Myofascial Release/ Joint Mobilizations □ Sports Rehabilitation / Return to Sport
* Post- Stroke Interventions □ Home Safety and Functioning Assessment
* Post- Amputee Interventions □ Patient Education / Custom Home Exercise Program

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Frequency & Duration** | | | | | | | | | | |
| **Frequency:** |  | Therapist Discretion |  | 1 x Week |  | 2 x Week |  | 3 x Week |  | 5 x Week |
| **Duration:** |  | Therapist Discretion |  | 4 Weeks |  | 6 Weeks |  | 8 Weeks |  | 10 Weeks |

I hereby certify that these services as medically necessary for the patient’s plane of care.

**Physician’s Signature: Date: / /**