Occupational Therapy Referral

Date: [Date]

Referring Provider Information:

Name: [Provider Name]
Facility: [Clinic/Hospital Name]
Phone: [Phone Number]
Fax: [Fax Number]

Patient Information:

Name: [Patient Full Name]
DOB: [Date of Birth]
Phone: [Patient Phone]
Insurance: [Provider & ID Number]

Reason for Referral / Diagnosis:

[ICD-10 Code and Description of Condition]

Clinical History & Functional Limitations:

[Brief summary of patient history, current functional deficits, and onset date]

Requested Services:

[ ] Evaluation and Treatment
[ ] Activities of Daily Living (ADL) Training
[ ] Upper Extremity Rehabilitation / Splinting
[ ] Cognitive/Perceptual Assessment
[ ] Home Safety Evaluation
[ ] Wheelchair/Adaptive Equipment Assessment

Precautions / Contraindications:

[Weight bearing status, ROM restrictions, etc.]

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Referring Provider Signature

NPI Number: [NPI #]