

BANNER GOOD SAMARITAN OUTPATIENT REHABILITATION

Phone 602 839-2317

FAX 602 839-6200

Referral Form

PLEASE PRINT

FAX this form to Rehabilitation Scheduling

Pt. name _____ DOB _____

Address _____ City _____ Zip code _____

Home phone _____ Work phone _____ Cell _____

Diagnosis _____

Recommended Frequency of Therapy _____ Recommended Duration of Therapy _____

Primary Insurance:

Name _____ Phone number _____

SSN/GRP#/PLAN# _____ Auth# _____ Contact _____

Number of visits _____ Effective Date _____ Expiration Date _____

Secondary Insurance:

Name _____ Phone number _____

SSN/GRP#/PLAN# _____ Auth# _____ Contact _____

Number of visits _____ Effective Date _____ Expiration Date _____

PHYSICAL THERAPY

- Evaluation & treat
- Vestibular eval/treat
- Lymphedema eval/treat
- Incontinence Program

NEUROPSYCHOLOGY

- Evaluation

OCCUPATIONAL THERAPY

- Evaluation & treat
- Vestibular eval/treat
- Lymphedema eval/treat
- Adaptive Driving eval
- Wheelchair seating fitting
- Adaptive Driving training
- Wheelchair seating eval

SPEECH THERAPY

- Speech Language eval/treat
- Swallowing evaluation
- Voice eval and treat
- LVES – videostrobocopy
- AAC eval and treat
- FEES w or w/o dye
- TEP post laryngectomy

Physician's Name (Please print) _____

Physician's signature _____ Date _____

Address _____ Contact _____

Phone number _____ FAX _____