COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY
14901 Rindaldi St. Suite 335 Mission Hills Ca 91345 | Tel: (818) 365-9690| Fax: (818) 365-9199

Referral Form & Current Medical History

Patient's name: _____

Date of Birth: _____ Phone No: _____

Insurance: _____ Diagnosis: _____

Does Patient require Oxygen? No ☐ Yes ☐ if yes, (LPM: _____)

Services Requested:

☐ **Pulmonary Rehabilitation: Evaluation & Treatment**

(Including **Respiratory Therapy** and **Physical Therapy/Occupational Therapy Evalutions**)

Includes 6 minute walk test, Berg Balance, spirometry, pulse oximetry, endurance, pulmonary hygiene, gait training, upper/lower body strengthening, functional training in activities of daily living and self-care.

Frequency/Duration: 2-3x WK / ☐ 12 WKS or ☐ 10 WKS

☐ **Physical Therapy: Evaluation & Treatment**

Treatment may include: balance/gait training, therapeutic exercise, manual therapy, upper and lower body strengthening, musculoskeletal postural and functional assessment/training, neuro-rehab, modalities.

Frequency/Duration: _____ x WK / _____ WKS

☐ **Occupational Therapy: Evaluation & Treatment**

Treatment may include: therapeutic exercise, hand/shoulder/neck assessments, manual therapy, upper body strengthening, activities of daily living, self-care and modalities.

Frequency/Duration: _____ x WK / _____ WKS

Physician's Name: _____

Physician's NPI# : _____

Physician's Signature: _____ Date: _____

PLEASE FORWARD PATIENT MEDICAL HISTORY UPON REFERRAL

FREE TRANSPORTION!

Thank you for referring to Rapid Therapy

We look forward to working with you!