THERAPY TREATMENT REFERRAL

GOLD COAST PHYSIO

FACILITY / RESIDENCE

Contact@goldcoastphysio.com

REFERRAL SOURCE

☐ PCP ☐ HOSPITAL ☐ SNF ☐ SPECIALIST ☐ ASSISTED LIVING ☐ OTHER

PATIENT INFORMATION (OPTIONAL IF ATTACHING FACE SHEET)

PATIENT NAME: _____ **DATE:** _____

PATIENT ADDRESS: _____

PATIENT PHONE: _____ **PATIENT D.O.B.:** _____

P.O.A. / CONTACT NAME & PHONE: _____

PRIMARY INSURANCE / MEMBER ID: _____ **SECONDARY INSURANCE / POLICY #:** _____

DIAGNOSIS / REASON FOR REFERRAL / ADDITIONAL NOTES

DISCIPLINE TO EVALUATE & TREAT

☐ PT/OT ☐ PT PHYSICAL THERAPY ☐ OT OCCUPATIONAL THERAPY ☐ SLP

EVALUATE & TREAT AS INDICATED

☐ Therapeutic Exercise / Activity
☐ Transfer Training
☐ Gait / Endurance Training
☐ Balance / Fall Prevention
☐ ADL Training / Safety
☐ Home Safety Assessment
☐ Caregiver Education / Training
☐ Dementia / Cognitive Training
☐ Manual Therapy / Massage
☐ Pain Management
☐ Prosthetic / Orthotic Training
☐ Community Mobility Assessment
☐ Wheelchair / Assistive Device
☐ Postural Training
☐ Medication Management
☐ Swallowing / Oral Function
☐ Speech / Voice / Language
☐ HEP / Wellness

OTHER: _____

PHYSICIAN / NP / PA

PRINT OR STAMP NAME: _____ **NPI #:** _____

ADDRESS: _____ **PHONE:** _____

SIGNATURE: _____ **DATE:** _____

PATIENT CONSENT - PHI, SCREENINGS & INSURANCE VERIFICATION

I authorize Gold Coast Physio to discuss Protected Health Information (PHI), coordinate care, conduct clinical screenings, and verify insurance eligibility, benefits, coverage, and prior authorization as needed for treatment, payment, and healthcare operations.

PATIENT / REPRESENTATIVE SIGNATURE: _____ **DATE:** _____