



Referral for Neuro-Based Therapy

<input type="checkbox"/> Neuro Clinic of Idaho: <u>Meridian Location</u> Meridian Physical Therapy 2470 N Stokesberry Pl. Meridian, ID 83646 P:(208) 884-8323 F:(208) 855-5708 Ariel Podjun OTR/L Lexis Taylor PT, DPT, ATC Tonya Hylton, M.S., CCC-SLP	<input type="checkbox"/> Neuro Clinic of Idaho: <u>Nampa Location</u> Atlas Physical Therapy 5560 E. Franklin Nampa, ID 83687 P:(208) 463-0700 F:(208) 463-0760 Whitney Sauer OTR/L
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Patients Name: _____ Patients Date of Birth: _____

Patients Phone: _____ Date Ordered: _____

Evaluate and Treat RX Frequency _____ per week _____ weeks

Diagnosis/Surgical Procedure/Area of Brian Affected: _____

<input type="checkbox"/> Neuro-Based OT & SLP <ul style="list-style-type: none"> <input type="checkbox"/> Functional Cognition <input type="checkbox"/> Executive Function <input type="checkbox"/> Vision <input type="checkbox"/> Language/Communication <input type="checkbox"/> Swallow 	<input type="checkbox"/> Neuro-Based PT & OT <ul style="list-style-type: none"> <input type="checkbox"/> Arm/Han <input type="checkbox"/> Leg/Foot <input type="checkbox"/> Balance <input type="checkbox"/> Manual Therapy <input type="checkbox"/> Driving Evaluation (Off the Road)
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Precautions/Instructions: _____

Physician Signature _____

Print Name Please _____

In signing this referral, the physician certifies that rehabilitation is medically necessary.

