Baptist Rehabilitation Physician Referral





Date:	Time:	
Patient Name:	·	DOB:
Home #:	Work #:	Alternate #:
Diagnosis/ICD-10 Code:		
Special Instructions/Precautions:		
Significant Medical History:		
── Evaluate and Treat		
Physical / Occupational Therapy	Programs	
☐ Lower Extremity Rehab.	☐ Upper Extremity Rehab.	☐ Shoulder Rehab.
☐ Neuro Rehab.	☐ Vestibular/Balance Rehab.	☐ Functional Capacity Evaluation
☐ Lymphedema Management	☐ Pelvic Health	☐ Manual Therapy
☐ Joint Mobilization	☐ Muscle Re-education	☐ Soft Tissue Mobilization
☐ Exercise ☐ PROM/AROM/HEP	Other:	
Speech Therapy Programs		
☐ Clinical Swallow Evaluation & Treatment		☐ Modified Barium Swallow Study
☐ Fiberoptic Endoscopic Evaluation of Swallowing (FEES) & Treatment		☐ Voice Evaluation & Treatment
☐ Speech/Language/Cognitive Eva	lluation & Treatment	
☐ Vital Stim/Neuromuscular Electr	rical Stimulation	
Physician Signature:	Dat	e: Time:

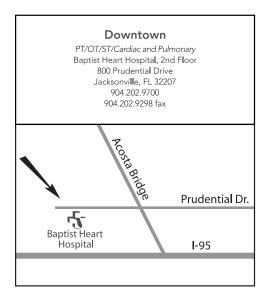
BAPTIST Rehabilitation

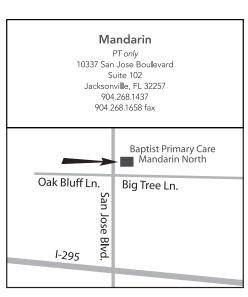
Baptist Medical Center Jacksonville, Jacksonville, FL
Baptist Medical Center Beaches, Jacksonville Beach, FL
Baptist Medical Center Nassau, Fernandina Beach, FL
Baptist Medical Center South, Jacksonville, FL
Wolfson Children's Hospital, Jacksonville, FL BAPTIST REHABILITATION PHYSICIAN REFERRAL



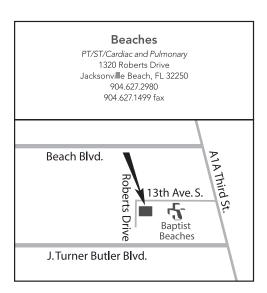
PATIENT LABEL

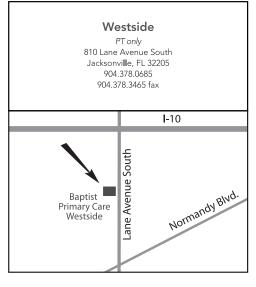
Baptist Rehabilitation

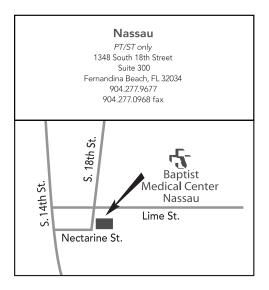














For more information about our services and locations, go to: www.baptistjax/rehab.