CENTRUM
THERAPY SERVICES

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Centrum Physical Therapy Referral Form

Source: ▢ PCP ▢ Hospital ▢ SNF ▢ Acute Rehab ▢ Specialist ▢ Home Health ▢ Other: _____

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Phone: (Mobile/Home) _____

Primary Insurance: _____ Policy ID#: _____

Secondary Insurance: _____ Policy ID#: _____

Medical Diagnosis: _____ ICD-10 Code: _____

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If post-acute follow-up, expected discharge date: _____

▢ Evaluate and Treat Onset Date: _____

Requested Frequency: _____ times/week x _____ weeks

▢ Post-op; Please list surgery performed: _____

▢ Balance training ▢ Manual Therapy ▢ Therapeutic Exercise ▢ Therapeutic Activity ▢ ROM

▢ ADL training/safety ▢ Home Safety Assessment ▢ Prosthetic or Orthotic fitting/training

▢ Transfer Training ▢ Gait Training/Endurance ▢ Wheelchair Training ▢ Pain management

▢ Other:_____

Additional Notes/Precautions:_____

_____

_____

_____

Referring Physician's Name/Specialty: (Please Print) _____

Referring Physician's NPI #: _____

Practice or Physician's Address: _____

Office Telephone: (_____) _____ Office Fax: (_____) _____

I certify that the above Therapy services are medically necessary and approved by me.

Referring Physician's Signature: _____ Date: _____