

“Because Life Doesn’t Stop for a Disability”

**OUTPATIENT REFERRAL**

Patient: \_\_\_\_\_ Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Precautions/Parameters: \_\_\_\_\_

Physician Ordering Care: \_\_\_\_\_

Physician Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Pager: \_\_\_\_\_

Who should we contact if we have questions?

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Physical Therapy**

Evaluation & Treatment Other: \_\_\_\_\_

Frequency: \_\_\_ 1x/wk \_\_\_ 2x/wk \_\_\_ 3x/wk Other: \_\_\_\_\_

Duration: \_\_\_ 1-2 wks \_\_\_ 3-4 wks \_\_\_ 6-8 wks Other: \_\_\_\_\_

**Occupational Therapy**

Evaluation & Treatment Other: \_\_\_\_\_

Frequency: \_\_\_ 1x/wk \_\_\_ 2x/wk \_\_\_ 3x/wk Other: \_\_\_\_\_

Duration: \_\_\_ 1-2 wks \_\_\_ 3-4 wks \_\_\_ 6-8 wks Other: \_\_\_\_\_

**Speech Language Therapy**

Evaluation & Treatment Other: \_\_\_\_\_

Swallowing Evaluation  Modified Barium Swallow

Frequency: \_\_\_ 1x/wk \_\_\_ 2x/wk \_\_\_ 3x/wk Other: \_\_\_\_\_

Duration: \_\_\_ 1-2 wks \_\_\_ 3-4 wks \_\_\_ 6-8 wks Other: \_\_\_\_\_

**Physician’s Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

\*\* Electronic submission is enough to begin the referral process. However, treatment cannot begin without a signed order, which can be mailed or faxed to: Schwab Rehabilitation Hospital – 1401 S. California Blvd., Chicago, IL 60608-1797.  
**Fax:** (773) 522-5840.