

**REFERRING PROVIDER / FACILITY**

Provider / Facility Name \*

Contact Name

Phone \*

Fax

**PATIENT INFORMATION**

Patient Name \*

Date of Birth \*

Patient Phone \*

Insurance & Member ID \*

Address \*

City \*

State \*

ZIP Code \*

**REASON FOR REFERRAL**

Diagnosis / ICD-10 \*

**THERAPY SERVICES REQUESTED**

PT Eval & Treat

Balance / Falls

Post-Surgical

Strength / Mobility

Gait Training

Neurological

Pain

Other \_\_\_\_\_

**FREQUENCY / DURATION**

**SPECIAL INSTRUCTIONS / ADDITIONAL NOTES**

**ATTACHMENTS (OPTIONAL)**

Office Note

Imaging

Medication List

Other \_\_\_\_\_

**PROVIDER SIGNATURE**

Provider Name / Signature \*

Date \*

**Secure & Confidential:**

Patient information is handled with confidentiality and care.  
Please fax completed referrals to (888) 506-5780 or email info@continuityhs.com.