THE QUEEN'S MEDICAL CENTER WEST O'AHU

OUTPATIENT REHABILITATION SERVICES REFERRAL FORM

PHONE: 691-3879 FAX: 691-3876

EMAIL: WESTOPREHAB@QUEENS.ORG

☐ Physical Therapy	☐ Occupational Therapy	☐ Speech Therapy

PATIENT INFO

Patient Full Legal Name: _____ **DOB:** _____

Phone Number: _____ **E-Mail Address:** _____

Insurance: _____

REASON FOR REFERRAL

Diagnosis:	**ICD-10#:**	**Date of Onset/Surgery:**

Reason for Referral/Functional Limitation:

Special Requests (Precautions, provider, protocol, specific interventions)**:**

Please attach a copy of the current history or last visit notes, including surgical reports and protocols*

☐ EVALUATION AND TREATMENT

Location:	**Location:**	**Location:**
❑ West Oahu	❑ West Oahu	❑ West Oahu
❑ Punchbowl	❑ Punchbowl	❑ Punchbowl
❑ Women's Health	❑ Women's Health	❑ Women's Health
❑ Hawaii Kai	❑ Hawaii Kai	❑ Hawaii Kai

Physical Therapy	**Occupational Therapy**	**Speech Therapy**
❑ Post-Op Rehabilitation	❑ Post-Op Extremity Rehabilitation	❑ Dysphagia (Swallow) Evaluation
❑ Neurologic Rehabilitation	❑ Splint Fabrication/Training	❑ Modified Barium Swallow (MBS)
❑ Sports Rehabilitation	Type: _____	❑ FEES
❑ Fall Prevention	❑ Neurologic Rehabilitation	(Fiberoptic Endoscopic Evaluation of Swallowing)
❑ Manual Therapy	❑ Workstation Evaluation/Ergonomic	❑ Speech
❑ Balance/Proprioceptive Training	Assessment	❑ Voice
❑ Other: _____	❑ Activities for Daily Living Training	❑ Language
	❑ Joint Protection/Energy Conservation	❑ Cognition
	Techniques	❑ AAC (Augmentative/ Assistive Communication)
	❑ Manual Training	❑ Other: _____
	❑ Other: _____	
		Is patient currently residing in a SNF Facility or receiving Home Health Services? If yes, please indicate.
		SNF: _____
		Home Health: _____

I certify that services will be furnished while the patient is under my care:

Print Referring Provider Name:	**Phone #**	**Fax #**

Referring Provider Signature:	**Date:**