



Client Name: _____ DOB: _____

Diagnosis: _____ ICD-10: _____

Concussion Clinic Evaluate & Treat

- o OT o PT o SLP

Speech Therapy Evaluate & Treat

- o Post-Concussion Protocol/Therapy
- o Executive Functioning
- o Mild Cognitive Impairment
- o Attention
- o Memory
- o Aphasia
- o Language
- o Dysarthria
- o Apraxia
- o Fluency
- o Voice
- o LSVT LOUD
- o Dysphagia/Swallowing
- o AAC
- o _____

Physical Therapy Evaluate & Treat

- o Post-Concussion Protocol/Therapy
- o Fall Risk Assessment
- o Wheelchair/Seating Evaluation
- o Prosthetic training
- o Vestibular/Balance
- o Visual Motor Integration/Therapy
- o Strengthening
- o Gait Training
- o Transfer Training/Functional Mobility
- o Soft Tissue Mobilization
- o HEP
- o Modalities/Manual Therapy
- o PWR! for Parkinson's
- o _____

Occupational Therapy Evaluate & Treat

- o Post-Concussion Protocol/Therapy
- o Attendant Care Assessment
- o Home Safety Assessment
- o Whole Brain Exercise
- o Neuromuscular Re-Ed
- o Therapeutic Exercise
- o Reflex Integration/MNRI
- o Desensitization/Sensory Integration
- o Executive Functioning
- o ADL/IADL
- o Community Reintegration
- o Home Organizational Strategies
- o Upper Extremity Functioning
- o Fine/Gross Motor Coordination
- o Compensatory Strategies
- o Visual Therapy/Visual Motor Integration
- o Functional Mobility/Safety
- o Manual Therapy
- o Technology Training
- o Prevocational Skill Training
- o _____

Group Therapy (OT/PT/SLP)

- o Communication Group
- o Brain-Body-Balance
- o Community Re-Entry
- o Art Exploration
- o Entrepreneurship Skills
- o _____

Cranial Sacral/ Myofascial Release (PT/OT)

Modalities: _____

Frequency: _____ Duration: _____

Notes: _____

Physician Signature: _____ Date: _____

Printed Name: _____ NPI#: _____

Please fax this referral to 734-433-1989. THANK YOU!