MERIDIAN NEURO REHAB

BRAIN AND BALANCE CENTER

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THERAPY REFERRAL PRESCRIPTION

PT & SPEECH THERAPY

PATIENT NAME _____ DATE OF BIRTH _____

PHONE _____ EMAIL _____

DIAGNOSIS / CLINICAL INDICATION _____ ICD-10 _____

NEURO-VESTIBULAR PHYSICAL THERAPY

- ☐ Vestibular Rehabilitation
- ☐ Post-Concussion Rehabilitation
- ☐ Dizziness / Vertigo / Refractory BPPV
- ☐ Balance & Gait Training
- ☐ Cervicogenic Dizziness
- ☐ Parkinson's / Movement Disorder (LSVT-style)
- ☐ Stroke / TBI Neuro Rehabilitation
- ☐ Fall Risk / Deconditioning
- ☐ PPPD / MdDS
- ☐ Other: _____

SPEECH & LANGUAGE THERAPY

- ☐ Aphasia / Language Recovery
- ☐ Cognitive-Communication Therapy
- ☐ Dysarthria / Motor Speech
- ☐ Voice Therapy & Vocal Function
- ☐ Swallowing Evaluation (Dysphagia)
- ☐ TBI / Concussion Cognitive Recovery
- ☐ Auditory Processing Disorder
- ☐ Apraxia of Speech
- ☐ Parkinson's Disease
- ☐ Other: _____

ORDERS

☐ Evaluate & treat per plan of care ☐ Frequency ____ ×/wk ☐ Duration ____ wks ☐ Records attached

PRECAUTIONS, RESTRICTIONS & RELEVANT HISTORY _____

GOALS / SPECIFIC REQUESTS _____

REPORT BACK TO ME: ☐ Initial evaluation findings ☐ Midpoint progress ☐ Discharge summary

REFERRING PROVIDER (PRINT) _____ NPI _____

SIGNATURE _____ DATE _____

PRACTICE _____ PHONE _____ FAX _____