

Outpatient Therapy Referral Form

Rehabilitation Services
Kootenai Health Campus
2003 Kootenai Health Way
Coeur d'Alene, ID 83814
208-625-5311 tel 208-625-4184 fax

Rehabilitation Services
Kootenai Clinic Post Falls
1300 E Mullan Ave., Suite A
Post Falls, ID 83854
208-625-5333 tel 208-625-5377 fax

Rehabilitation Services Riverstone
2236 N. Merritt Creek Loop
Coeur d'Alene, ID 83814
208-625-4100 tel 208-625-4101 fax

Rehabilitation Services Ironwood Center Dr.
2180 W. Ironwood Center Dr.
Coeur d'Alene, ID 83814
208-625-3680 tel 208-625-3681 fax

Patient's Name: _____ Phone: _____
Last Name First Name M.I.

D.O.B.: _____ Date of onset: _____

OCCUPATIONAL THERAPY - Evaluate and treat as indicated:

Diagnosis: _____ ICD Code: _____

- | | |
|---|---|
| ☐ Evaluate and treat | ☐ Splinting/Orthotics |
| ☐ Cognitive | ☐ Upper Extremity/Hand |
| ☐ Comprehensive Driving Evaluation | ☐ Community/Adaptive equipment |
| ☐ LSVT Big | ☐ NCSE |
| ☐ Other _____ | ☐ Functional Capacity Evaluation |
| | ☐ Cognitive Performance Test (CPT) |
| Frequency/Duration: _____ | ☐ Telehealth |

PHYSICAL THERAPY - Evaluate and treat as indicated:

Diagnosis: _____ ICD Code: _____

- | | |
|--|---|
| ☐ Evaluate and treat | ☐ Pelvic Floor Evaluation for Pain |
| ☐ Aquatic Therapy | ☐ Pelvic Floor Evaluation for Incontinence |
| ☐ Epley Maneuver for BPPV | ☐ Functional Capacity Evaluation |
| ☐ Spine and Orthopedic Rehabilitation | ☐ Neurological Rehabilitation |
| ☐ Wheelchair Evaluation | ☐ Astym / Instrument assisted soft tissue mobilization |
| ☐ Lymphedema Management | ☐ LSVT Big |
| ☐ Other: _____ | ☐ Telehealth |

Frequency/Duration: _____

SPEECH THERAPY - Evaluate and treat as indicated:

Diagnosis: _____ ICD Code: _____

- | |
|---|
| ☐ Speech, Language, Cognition |
| ☐ Voice (VLS if indicated) ☐ Yes ☐ No |
| ☐ Clinical Bedside Swallow (Modified Barium Swallow / FEES if indicated?) ☐ Yes ☐ No |
| ☐ Neuromuscular Electrical Stimulation (NMES) for Treatment of Dysphagia |
| ☐ LSVT Loud |
| ☐ Telehealth |
| ☐ Other _____ |

Frequency/Duration: _____

Medical Professional Signature

Date

Time

Medical Professional Name (PLEASE PRINT)

Visit Kh.org/rehab to download and print our location maps

Patient Identification – Write in or attach patient label

Name:

MRN #:

CSN #:

Age/Sex:



Referral Attachment

Reviewed Sept 2024

Page 1 of 1