## Patient Information (Required for Scheduling)

Patient Name: _____ DOB: _____ Sex: ❑ M ❑ F SS#: _____
First & Last Name

Patient's Address: _____ _____ _____ _____
Street City State Zip Code

Home Phone#: _____ Mobile Phone #: _____ Email Address: _____

Primary Insurance: _____ Policy #: _____ Group #:_____ Phone #:_____
Plan & Product

Secondary Insurance: _____ Policy #: _____ Group #:_____ Phone #:_____
Plan & Product

## Order Information - Outpatient Rehabilitation

**Evaluate and treat as indicated: ❑ Occupational Therapy ❑ Physical Therapy ❑ Speech Therapy**

Special Instructions: _____

Diagnosis: _____

ICD-CM Diagnosis Code: _____

**Please check any that apply, as pre-certification / benefit check may be required.**

❑ Amputee Therapy
❑ Aquatic Therapy (OT/PT) @ North Decatur Only
❑ Augmentative Alternative Communication (ST)
❑ Balance / Vestibular Rehabilitation
❑ Breast Cancer Rehab / Breast Health
❑ Cancer Rehab
❑ Cognitive Retraining (ST)
❑ Core/Lumbar Stabilization
❑ Driving Evaluation @ North Decatur Only
❑ Dry Needling
❑ Functional Capacity Evaluation (FCE)
❑ Hand Therapy (OT) / Splinting
❑ Iontophoresis with Dexamethasone (PT/OT)
❑ Lymphedema Therapy (PT/OT)
❑ Otago Falls Prevention Program
❑ Parkinson's Disease *LSVT BIG* Program (PT) @ North Decatur Only
❑ Parkinson's Disease *LSVT LOUD* Program (ST) @ Hillandale Only
❑ Female Pelvic Floor Dysfunction / Incontinence
❑ Pregnancy Dysfunction
❑ Swallow Evaluation / Treatment
❑ Vital Stimulation© (ST)
❑ Voice Therapy (ST)
❑ Wheelchair Seating Assessment @ North Decatur Only
❑ Work Hardening / Work Conditioning

***For Medicaid referrals, we must be provided with date of onset, diagnosis and supporting clinical notes in order to obtain authorization to treat your patient.***

## Referring Physician Information

Physician Name (first & last): _____ NPI#: _____ GA License#: _____

Physician Address: _____ Phone#: _____ Fax #:_____

**I herby certify that the services indicated in the above order form are medically necessary.**

Physician Signature: _____ Date: _____ Time:_____

DeKalb Medical

**N. Decatur** - FAX Orders to: 404.501.7186
Phone: 404.501.5140
**Hillandale** - FAX Orders to: 404.501.8387
Phone: 404.501.8140

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# OUTPATIENT REHABILITATION ORDER FORM

DMC FORM # PS-1057 (02/10/17)