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

P S - 1 0 5 7

OUTPATIENT REHABILITATION ORDER FORM

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