

REFERRAL FOR OUTPATIENT REHABILITATIVE SERVICES

Outpatient Specialty Clinics & Neuro Rehabilitation (PT/OT/SLP)

515 Ray C. Hunt Dr.
Charlottesville, VA 22903
434 244-2013 • Fax 434 244-2014

Outpatient Sports Medicine & Rehabilitation Center (PT/Hand Therapy)

545 Ray C. Hunt Dr., Suite 210
Charlottesville, VA 22903
434 243-0311 • Fax 434 243-0320

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- | | |
|---|--|
| <input type="checkbox"/> Amputee Program
<input type="checkbox"/> Aquatic Therapy
<input type="checkbox"/> Arthritis Program
<input type="checkbox"/> Brain Injury (traumatic & non-traumatic)
<input type="checkbox"/> Chronic Pain; Fibromyalgia
<input type="checkbox"/> Low vision (macular, diabetic retinopathy, glaucoma)
<input type="checkbox"/> Lymphedema
<input type="checkbox"/> Neuro Disorders
<input type="checkbox"/> Oncology Program
<input type="checkbox"/> Orthopedic (multi-trauma, fractures, pre-/post-surgical joint replacements)
<input type="checkbox"/> Seating Clinic/Wheelchair-Cushion Assessments
<input type="checkbox"/> Spinal Cord Injury
<input type="checkbox"/> Stroke
<input type="checkbox"/> Vestibular/Balance Program
<input type="checkbox"/> Women's Program (incontinence, pelvic floor; pain/weakness, pregnancy related conditions, osteoporosis)
<input type="checkbox"/> Speech & Language Therapy - Cognition; Dysphagia | <input type="checkbox"/> Spine Program - acute, non-surgical and post-op
<input type="checkbox"/> Foot / Ankle Programs
<input type="checkbox"/> Sports Medicine & Runners Clinic
<input type="checkbox"/> General Ortho Program - shoulder & knee injuries (non-surgical & post-op)
<input type="checkbox"/> Back School
<input type="checkbox"/> Bike evaluation and Running evaluations
<input type="checkbox"/> Industrial Rehabilitation / FCEs
<input type="checkbox"/> Hand Therapy / Custom Splinting |
|---|--|

Name: _____ Date: _____

Phone #: _____ Work #: _____

Diagnosis: _____

Surgical Procedure: _____ Date of Surgery: _____

Other: _____

PHYSICAL THERAPY

HAND THERAPY (PT/OT)

OCCUPATIONAL THERAPY

SPEECH THERAPY

EVALUATE AND TREAT

SPECIFY: _____

_____ Times per week for _____ Weeks

Therapist Discretion

Physician Signature: _____ Phone #: _____

