OUTPATIENT NEURO REHABILITATION REFERRAL FORM

ON WITH LIFE
BRAIN INJURY + STROKE + NEURO

Patient Name: _____

Date of Birth: _____ Patient Phone: _____

REFERRAL OPTIONS (TO EVALUATE AND TREAT AS APPROPRIATE)

- ☐ Neuro-Rehabilitation Clinic
  PT/OT/SP as appropriate
- ☐ Complex Concussion Clinic
  PT/OT/SP as appropriate
- ☐ Parkinson's Clinic - including LSVT BIG and LOUD
  PT/OT/SP as appropriate
- ☐ Wheelchair Positioning/Fitting Clinic
  PT/OT as appropriate
- ☐ Healthy Aging Clinic/Fall Prevention Clinic
  PT/OT as appropriate
- ☐ Aquatic Therapy (Ankeny campus only)
  PT/OT as appropriate
- ☐ Cognitive Rehabilitation
  OT/SP as appropriate
- ☐ Balance and Vestibular Rehabilitation
  PT/OT as appropriate
- ☐ Vision Rehabilitation
  OT as appropriate
- ☐ Cognitive Rehabilitation following cancer diagnosis
  PT/OT/SP as appropriate
- ☐ Counseling
- ☐ Neuropsychological Evaluation (Ankeny campus only)

PREFERRED LOCATION

- ◯ Ankeny Campus
  715 SW Ankeny Road, Ankeny
  Ph: 515-289-9696 | **Fax: 515-289-9649**
- ◯ Coralville Campus
  2854 Coral Court, Suite 1, Coralville
  Ph: 319-259-6224 | **Fax: 319-249-6643**

Please fax completed form to the appropriate campus (fax numbers above). Patient will be contacted to schedule an appointment. Please include with this referral form:

- **Demographics/intake sheet, including insurance card(s)**
- **Reason for diagnosis or referral**
- **All documents supporting referral diagnosis**

**We cannot schedule until this information is returned to our office.*

Reason for Referral: _____

Diagnosis Codes: _____

Physician Name: _____

Provider Signature: _____ NPI: _____ Date: _____

Clinic: _____ Phone: _____