

JUST BE FIT, INC.

EXERCISE BASED REHABILITATION

420 Lake Cook Rd, Suite 101
Deerfield, IL 60015
Ph 847-444-1348 Fax 847-444-1349

PHYSICIAN / THERAPIST REFERRAL FORM I

I Instructions to Physician/Therapist

1. Complete patient name and information in Section II
2. Complete your name and information in section II
3. Please include all known diagnoses by ICD-9 code. If BWC case, please include claim number. If precertification is required, please include code/number.

II Patient Name: _____ Phone: _____
Physician/Therapist Name: _____ Phone: _____
Diagnosis (ICD-9): _____ BWC Claim # _____ Precertification Code # _____

III Patient Category

- | | |
|---|--|
| <input type="checkbox"/> Post Physical Therapy/Rehabilitation | <input type="checkbox"/> Geriatric |
| <input type="checkbox"/> Sedentary | <input type="checkbox"/> Prepubescent Adolescent |
| <input type="checkbox"/> First-Time Exerciser | <input type="checkbox"/> Pre-Surgery on ____/____/____ |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Poor Balance and Unstable |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Gait Dysfunction |
| <input type="checkbox"/> Post-Surgery on ____/____/____ | <input type="checkbox"/> High-Risk Factors CAD |
| <input type="checkbox"/> Inflexibility | <input type="checkbox"/> Sport |

Specific _____

- | | |
|---|--|
| <input type="checkbox"/> Posture/Standing Alignment | <input type="checkbox"/> Diabetes Type _____ |
|---|--|

IV Requested Service(s)

- | | |
|--|--|
| <input type="checkbox"/> Consultation | <input type="checkbox"/> Posture Training |
| <input type="checkbox"/> Adherence Risk Profile | <input type="checkbox"/> Stress Control/relaxation Program |
| <input type="checkbox"/> Pre-Exercise Assessment | <input type="checkbox"/> Nutrition Review |
| <input type="checkbox"/> Exercise Program Design | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Muscle Balance Testing | |

V Medications

VI _____ has my approval to begin the above services with the recommendations and contraindications stated above. Please (circle one – cross out other)

- I would / would not like to pursue insurance reimbursement.
I would / would not like to receive progress reports every _____ weeks.

Physician/Therapist Signature _____ License # _____ Date _____

PLEASE FAX TO (847) 444-1349 WHEN COMPLETE. THANK YOU.

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THERAPIST REFERRAL FORM II

Initial Evaluation

Patient Name _____ Date of Birth _____
Diagnosis _____ Date of Progress Evaluation _____
Referring Physician _____ Date of Onset _____

Subjective:

Treatment: AROM/ POROM/ AAROM/ Strength Training/ Posture Training/ Trunk Stab. Ex Closed Kinetic Chain Strengthening/ Modalities including: _____

Home Exercises Instruction for: _____

Objective reports:

| 1) Range of Motion: | AROM | PROM | 2) Strength |
|---------------------|-------|-------|-------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

3) Palpation _____

4) Special Testing/Functional Impairment _____

Assessment:

Prognosis:

Goals: Short term to be achieved in _____ weeks.
1) _____
2) _____
Long term to be achieved in _____ weeks.
1) _____
2) _____

Plan:

Thank you for this referral.

Sincerely,
