Independent Living Therapy Services, LLC
Occupational Therapy
2727 San Pedro NE Suite 116
Albuquerque NM, 87110
Office: (505) 433-2146 Fax: (505) 508-2305
Email: ilts@therapyabq.com

Referral for Occupational Therapy Services

Patient Information:

First Name:		**Last Name:**		**DOB:**
Address:			**Ph#1:**	
City:	**State:**	**Zip:**	**Ph#2:**	
Primary Ins.:		**ID#:**		
Sec. Ins.:		**ID#:**		
Diagnosis:				
ICD-10 Code(s):				
Precautions:				

Frequency:	Daily ☐	3x/week ☐	2x/week ☐	Weekly ☐	1x visit ☐	1-2 visits ☐
Duration:	1 week ☐	2 weeks ☐	3 weeks ☐	1 month ☐	2 months ☐	3 months ☐

Occupational Therapy Services:

- ☐ Evaluate and Treat
- ☐ Hand/Upper Extremity Therapy
- ☐ Shoulder Rehabilitation
- ☐ Therapeutic Exercise
- ☐ Postural Re-education
- ☐ Splinting
- ☐ Manual Therapy
- ☐ Self-Care Training/ Adaptive Equipment
- ☐ Home Exercise Program
- ☐ Wheelchair Seating Evaluation/Pressure Mapping
- ☐ Neuromuscular Re-education
- ☐ Complex Rehab Technology Evaluation
- ☐ Assistive Technology Evaluation
- ☐ Home Safety Evaluation

I certify that therapy services for the above- named patient are or were required on an outpatient basis under a plan established and received within 90 days by me as the attending physician while the patient is or was under my care. Further, the written plan established is contained in the patient's records and prescribes the type, amount and duration of the therapy services.

Please print clearly

Licensed Medical Provider Name & Credentials: ______________________________

Phone: ______________________ Fax: ______________________________

Licensed Medical Provider Signature: ______________________________

Date: ______________________ NPI: ______________________________