Covell Care & Rehabilitation

Outpatient Therapy Order

Date: _____

Patient Name: _____ **DOB:** _____

Address: _____

Sex (circle one): ☐ **M** / ☐ **F** **Phone:** _____

Alternate Contact Name and Phone Number: _____

Ordering Physician/NP Name/Phone/Fax:

_____

Services/Disciplines Ordering:

☐ Physical Therapy _____

☐ Occupational Therapy _____

☐ Speech Therapy _____

☐ Off-Road Driving Assessment _____

☐ Licensed Clinical Social Work _____

☐ Fitness Training _____

☐ Pelvic Health _____

Specific Order Details: _____

_____

_____

_____

Diagnosis: (Please include ICD-10 codes): _____

_____

_____

NP/Physician Signature: _____ **Date:** _____

Please include the following with order: Face Sheet, Insurance Info, H&P, Medication List, Last Visit Note, Nursing Notes, Therapy Notes, and/or Lab Results.

Covell Care & Rehabilitation • 970.204.4331 ph • 970.204.6712 fx