



One Medical Center Drive
P.O. Box 626
Biddeford, ME 04005-0626

OUTPATIENT REHABILITATION REFERRAL

**SMMC Diagnostic & Therapy Center
Kennebunk**
4 Shape Drive
Kennebunk, Maine 04043
Phone: (207) 467-6999 / Fax: (207) 467-6996

**SMMC Diagnostic and Therapy Center
Saco**
13 Industrial Park Road
Saco, Maine 04072
Phone: (207) 294-8181 / Fax: (207) 294-8188

**SMMC Diagnostic & Therapy Center
Biddeford**
9 Healthcare Drive
Biddeford, ME 04005
Phone: (207) 602-7034 / Fax: (207) 283-1753

Patient Name: _____ Telephone: _____

Diagnosis(es) Pertinent to Rehabilitation Referral: _____

Date of Onset: ____/____/____ **OR** Long-standing Condition: _____
MM DD YY Approximate Time Frame

Pertinent medications/clinical findings/precautions: _____

Physical Therapy: Eval & Treat
 Occupational Therapy: Eval & Treat
 Speech Language Pathology: Eval & Treat

Iontophoresis **Phonophoresis**
____ w/ Dexamethasone ____ w/ Fluocinonide
____ w/ Acetic Acid ____ w/ Hydrocortisone

SPECIALIZED OUTPATIENT PROGRAM:

- | | |
|---|--|
| <input type="checkbox"/> Neuro Rehab: PT, OT, ST | <input type="checkbox"/> Balance / Vestibular: PT |
| <input type="checkbox"/> Driving Evaluation: OT | <input type="checkbox"/> Incontinence / Pelvic Floor: PT |
| <input type="checkbox"/> Aquatic Therapy: PT 2x/wk | <input type="checkbox"/> Functional Capacity Eval: OT |
| <input type="checkbox"/> Hand Therapy / Splinting: OT | <input type="checkbox"/> Dysphagia Therapy (Swallow Program): ST |

Specific Instructions: _____

FREQUENCY & DURATION: (required to implement services)

- As determined by Therapist As specified ____ per week for ____ weeks

Physician Signature (required): _____

Date (required): _____