NYU Medical Center **RUSK INSTITUTE** of Rehabilitation Medicine

REFERRAL FOR OUTPATIENT **PHYSICAL THERAPY**

FAX to the RUSK BUSINESS OFFICE (212) 263-0113

Date: _____

Patient Name: _____
Patient Date of Birth: _____ Patient Social Security Number: _____
Patient Telephone Number: Contact 1: (_____)_____-_____
Contact 2: (_____)_____-_____
Patient Address: _____
_____
Primary Insurance: _____ Policy Number: _____ Insured Name: _____
Secondary Insurance: _____ Policy Number: _____ Insured Name: _____

Medical Diagnosis: _____ ***ICD 9:*** _____
Prescription for Evaluation and Treatment Including: (please select)
_____Therapeutic Exercise
_____Manual Therapy
_____Gait Training
_____Modality (including electrical stimulations)
_____Other _____

Onset Date: _____

Precautions: _____
_____
_____

Physician Order Frequency and Durations: _____ _____
(times/week) (number of months)

Physician's Name: _____
License Number: _____ UPIN: _____
Office Telephone: _____ Office Fax: _____
Physician's Signature: _____