



IN HOME THERAPY REFERRAL - REQUEST FORM

TEL: (631) 596-5096
 FAX: (631) 594-5370
www.greinerpt.com

“Get Better Faster from the
 Comfort of Home”
 Serving Eastern Long Island

PATIENT INFORMATION

Name DOB

Address Phone #

Medicare # Secondary Insurance#

Physical Therapy Fitness Training(Private Pay)
 Evaluate and Treat Continue Therapy

Manual Therapy/Modalities	Therapeutic Exercise	Specialty Programs
<input type="checkbox"/> Joint Mobilization	<input type="checkbox"/> AROM	<input type="checkbox"/> Fall Prevention Training
<input type="checkbox"/> Myofascial Release	<input type="checkbox"/> AAROM	<input type="checkbox"/> Post-Surgical Rehabilitation
<input type="checkbox"/> Manual Traction	<input type="checkbox"/> PROM	<input type="checkbox"/> Spinal Stabilization Program
<input type="checkbox"/> Cold Pack	<input type="checkbox"/> Flexibility	<input type="checkbox"/> Gait/Balance Training
<input type="checkbox"/> Hot Pack	<input type="checkbox"/> Strengthening	<input type="checkbox"/> Parkinson’s Disease Program
<input type="checkbox"/> E-Stim	<input type="checkbox"/> Home Exercise Program	<input type="checkbox"/> Home Safety Assessment

DIAGNOSIS/REASON FOR REFERRAL

FREQUENCY AND DURATION

ADDITIONAL NOTES/PRECAUTIONS

I CERTIFY THAT PHYSICAL THERAPY IS MEDICALLY NECESSARY

PHYSICIAN NAME: _____ PHONE # _____

PHYSICIAN SIGNATURE: _____ DATE: _____

PHYSICIAN NPI: _____

THANK YOU FOR YOUR REFERRAL TO GREINER PHYSICAL THERAPY!
PLEASE FAX BACK TO 631-594-5370