



## Physician Referral for Outpatient Services

Referring Physician: \_\_\_\_\_ Fax: \_\_\_\_\_  
(Please Print) Phone: \_\_\_\_\_

To refer your patient to St. Camillus for Outpatient Services, please complete this form, include the appropriate information and return it to our Admissions Office via FAX: (315) 488-3804.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis/Reason for Referral (Required):  
\_\_\_\_\_

Please indicate any Specifications and/or Instructions for initiation of therapy services. Include any additional treatments if needed and a brief medical history. Use additional pages as necessary.

**PHYSICAL THERAPY**

Evaluate and Treat     Evaluate Only     Evaluate for Bioness L300

Other Specifications / Instructions: \_\_\_\_\_

**OCCUPATIONAL THERAPY**

Evaluate and Treat     Evaluate Only     Evaluate for Bioness H200

Other Specifications / Instructions: \_\_\_\_\_

**SPEECH/LANGUAGE THERAPY**

**SWALLOWING EVALUATION**

**MODIFIED BARIUM SWALLOW**

Evaluate and Treat     Evaluate Only

Other Specifications / Instructions: \_\_\_\_\_

**Other Service:** \_\_\_\_\_

Evaluate and Treat     Evaluate Only

Other Specifications / Instructions: \_\_\_\_\_

MD, PA or NP Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please call (315) 488-2112 with any questions. Thank you for referring your patient to St. Camillus Outpatient Services.