Snoqualmie Valley Health Rehab Referral

Patient Information

Name: _____ Birthdate: _____

Patient Phone #: _____ Insurance: _____

Diagnosis: _____

Date of Follow Up Appointment with Physician: _____

(Please check *ALL* services that apply)

Physical Therapy

□ **Evaluate and Treat**
□ **Frequency_____ Duration_____**
□ Spine Rehab
□ Sports Rehab
□ Neuro Rehab
□ Manual Therapy
□ Post Op Rehab
□ Balance Training / Fall Prevention
□ Gait Training
□ Vestibular Rehab
□ Pelvic Floor Rehab
□ TMJ Rehab
□ Work Conditioning / Reintegration
□ Postural Assessment & Training
□ Pain Management
□ Generalized Weakness
□ Other: _____

Occupational Therapy

□ **Evaluate and Treat**
□ **Frequency_____ Duration_____**
□ Neuro Rehab
□ Visual Therapy
□ Hand Therapy
□ Custom Upper Extremity Orthosis
□ Wheelchair Seating and Positioning
□ Durable Medical Equipment Fitting & Training
□ Self-Care Management & Training
□ Ergonomic Assessment
□ Pre-Driving Assessment, Clinic Only
□ Energy Conservation Training
□ Home Safety Assessment

Speech Therapy

□ **Evaluate and Treat**
□ **Frequency_____ Duration_____**
□ Neuro Rehab
□ Cognitive Assessment
(*Memory Impairment, Attention, Executive Functions*)
□ Communication Assessment
(*Aphasia, Apraxia, Dysarthria*)
□ Articulation and Phonological Disorders
□ Language delays and disorders
□ Voice Disorders
□ Auditory Processing Disorders
□ Swallowing Disorders
□ Speak Out!
□ Gender-Affirming Voice Training
□ Stuttering

Special Instructions

_____ _____ _____

Physician Name (*printed*) Signature Date