SWEDISH

Swedish Outpatient Rehabilitation Services

Occupational and Hand Therapy

Referral Form

Date: _____

Patient name: _____

Phone: _____ DOB: _____

DOI: _____ DOS: _____ Total visits: _____

Diagnosis: _____

Precautions: _____

OT

___ **Evaluate and treat**
___ Neurological Rehabilitation
___ Ergonomic Assessment
___ Low-vision Rehabilitation (*Ballard campus only*)
___ UE Lymphedema Management
___ Self-Care/ADLs
___ Other_____

HAND/UPPER EXTREMITY REHABILITATION – OT AND/OR PT

___ **Evaluate and treat**
___ Splint/Type: _____
___ Protocol: _____
___ A/PROM
___ Strengthening
___ Wound Care
___ Scar Management
___ Edema Control
___ Modalities *(circle):* US Phono Ionto
___ Electrical Stimulation
___ Joint Protection/Adaptive Equipment
___ Other: _____

Physician signature: _____

Physician's name *(print):* _____

Patient will see physician again on *(date):* _____

(maps on reverse side)

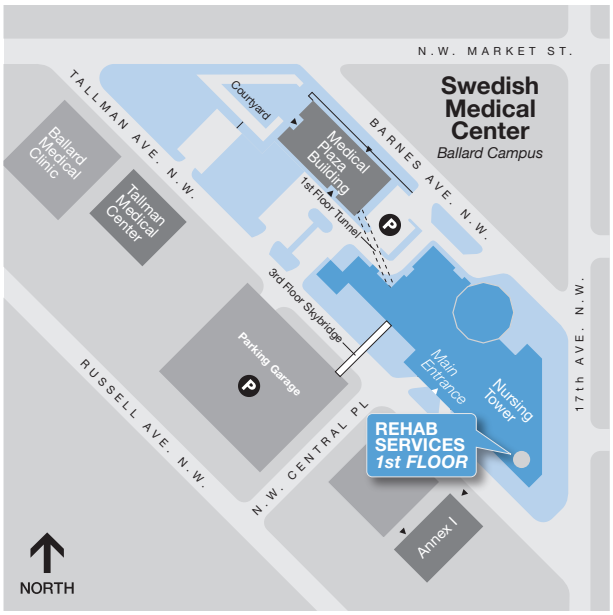
SWEDISH

Ballard
5300 Tallman Ave. N.W., 1-S
Seattle, WA 98107
T 206-781-6346
F 206-781-6191

Cherry Hill
500 17th Ave.
James Tower, Suite 100
Seattle, WA 98122
T 206-320-2404
F 206-320-4747

First Hill
1101 Madison, Suite 200
Seattle, WA 98104
T 206-386-2035
F 206-386-2999

For a free physician referral: 1-800-SWEDISH (1-800-793-3474)
www.swedish.org



Swedish Medical Center/Ballard
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5300 Tallman Ave. N.W., 1-S
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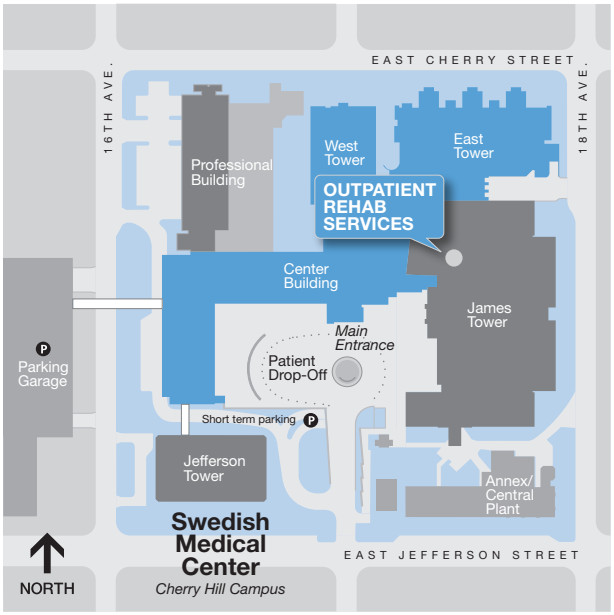

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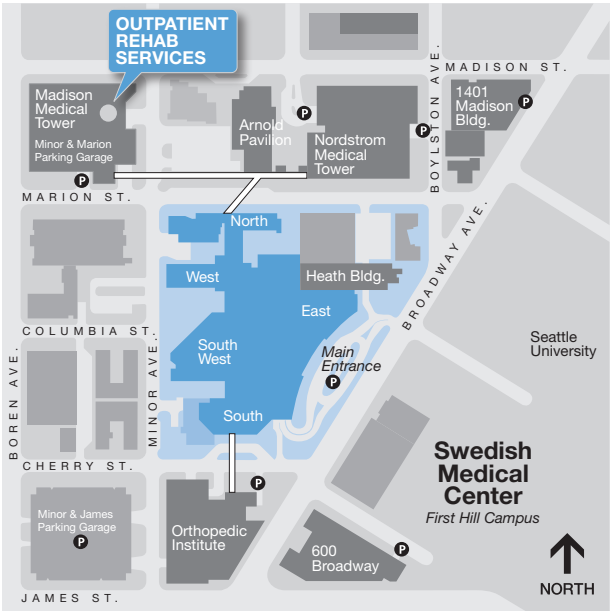

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