Optimae
REHABILITATION SERVICES

Rehabilitation Therapy Referral Form

Please attach a copy of your legal ID, insurance card and medication list

Preferred Name & Pronouns:

Legal Name:

Phone Number:

Insurance Coverage & Policy Numbers:

Birthdate:

Social Security Number:

Address:

Primary Care Provider and Phone Number:

Psychiatric Provider and Phone Number:

Check Desired Service: ☐ **Occupational Therapy** ☐ **Physical Therapy** ☐ **Speech/Cognition Therapy**

Referral Reason:

Medical Diagnoses:

Precautions/Restrictions:

Is there someone other than the customer who we should schedule with? Please list their name and phone number:

X_____ _____

Referrer signature *Date*

Please return this completed referral form to rehabinfo@optimae.com or fax to 515-381-9280. Once this referral is received the occupational therapist will reach out to the physician for approval and contact the indicated scheduler to set up the initial evaluation.