



COMPREHENSIVE OUTPATIENT  
REHABILITATION FACILITY

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

Telephone Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Respiratory Therapy Evaluation and Treatment

Treatment may include: Patient Education, Pulse Oximetry, Endurance Training, Breathing Retraining, Pulmonary Hygiene, Titration of Supplemental Oxygen

Other: \_\_\_\_\_

Physical Therapy Evaluation and Treatment

Treatment may include: Balance Training, Therapeutic Exercise, Neuromuscular Re-Education, Home Exercise Instruction, Gait Training, Vestibular Therapy

Other: \_\_\_\_\_

Social Service Evaluation

Special Instructions/Limitations: \_\_\_\_\_

\_\_\_\_\_

Physician Name: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_ NPI #: \_\_\_\_\_

**Please forward patient medical history upon referral.**

Refer to fax number from our website: [www.westcoastcorfs.com](http://www.westcoastcorfs.com)