USC Mrs T H. Chan Division of
Occupational Science and Occupational Therapy
Faculty Practice

Phone: (323) 442-3340 | Fax: (323) 442-3351 | otfp@med.usc.edu
Health Sciences Campus: 1640 Marengo Street, Suite 500, Los Angeles, CA 90033
University Park Campus: 1031 W. 34TH Street, Suite 452, Los Angeles, CA 90007

OCCUPATIONAL THERAPY REFERRAL FORM

Patient Legal Name:____DOB:____________

Patient Name (If different than legal name):____

Email Address: ____Phone: ______________

Diagnosis: ____ICD-10: _____________________

Diagnosis: ____ICD-10: _____________________

History/Precautions: ____

Physician's Name/Title:____________________________Phone: ____________ Fax:____________

Address: ____

Email: ____NPI #: _______________________

- ☐ OCCUPATIONAL THERAPY EVALUATION AND TREATMENT
- ☐ OCCUPATIONAL THERAPY EVALUATION AND REPORT (no treatment included)
- ☐ HOME and/or WORK EVALUATION (Safety, Adaptive Equipment, Ergonomics)

Lifestyle Redesign® is the development and enactment of health-promoting habits and routines designed to improve health and quality of life and prevent and control chronic health conditions.

Please select one or more Lifestyle Redesign® program(s):

- ☐ Weight / Diabetes Management
- ☐ Hand Therapy/Upper Extremity
- ☐ Pain Management
- ☐ Gender Affirming Care
- ☐ Chronic Headaches / Post-Concussion
- ☐ Behavioral and/or Mental Health
- ☐ Smoking Cessation and Relapse Prevention
- ☐ MCAS and Dysautonomia
- ☐ Ergonomics
- ☐ Gender Care
- ☐ Movement Disorders / Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ College Student
- ☐ Oncology
- ☐ Lifestyle Risk Assessment / Health Coaching
- ☐ Autism Spectrum Disorder/Asperger's
- ☐ Neurological conditions (e.g., epilepsy, post-stroke)
- ☐ Hypertension
- ☐ Pelvic Floor Health
- ☐ Sleep Disorders
- ☐ Other: ____

By signing below, I certify that I have examined the patient and that services will be furnished while the patient is under my care, and that the plan is established and will be reviewed every 90 days or more often if the patient's condition requires.

____ ____
PHYSICIAN'S SIGNATURE DATE