USC Mrs T H. Chan Division of
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Faculty Practice

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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):

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