Referral Form

Complete the following for referrals to:

Therapy Shoppe
93 Main St.
Mars Hill, ME 04758
P: (207) 810-4579 F: (207) 425-1036

Patient Name: _____ DOB: _____

Address: _____

Phone #: _____

Brief description of reason for referral and/or diagnosis: _____

_____ Check all that apply:

___ Lymphedema Evaluation and treatment

___ Compression garment measurement and fitting

___ Mastectomy Bra fitting

___ Mastectomy Prosthetic fitting

___ Other. Please describe. _____ ___

Strengthening ___ ROM ___ Hand therapy ___ ADL

___ Home modification recommendations for safety and independence

___ Adaptive equipment assessment and recommendations

Provider Name and Credentials: _____

NPI #: _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____

Provider's Signature: _____

Date: _____

Please, include a face sheet and pertinent medical records for the patient

Send to TS via fax (207) 425-1036 or scan to email therapyshoppeme@gmail.com