H2 HEALTH

PRESCRIPTION FOR THERAPY

FAX: **(904) 757-9679**

EMAIL: **referrals@h2health.com**

FACILITY LABEL

PATIENT INFORMATION (Please attach facesheet if possible)

Date: _____ Time: _____

Name: _____ DOB: _____

POA Name: _____ POA Phone: _____

☐ *EVALUATE & TREAT*

Circle all that apply

☐ PHYSICAL THERAPY ☐ OCCUPATIONAL THERAPY ☐ SPEECH LANGUAGE PATHOLOGY

REHABILITATION PROGRAMS
- Balance and Dizziness Correction
- Chronic Disease/Pain Management
- Healthy Lifestyles Program
- Gait Training & Endurance
- Postural Training
- Transfer Training
- Urinary Incontinence

ADL Training/Safety
Caregiver Education

COGNITIVE TREATMENT
- Cognitive Skills Development
- Dementia Management
- Assisted/Adaptive Device Manage.
- Environmental Safety Assessment
- DME Assessment

SPEECH SERVICES
- Swallowing Dysfunction/Oral Function
- Speech, Voice and Language Deficits

MOBILIZATION
- Manual Therapy/Massage
- Ultrasound
- Electrical Stimulation
- Cold Packs

Diagnosis/Reason for Referral/Additional Notes:

☐ EVALUATE & TREAT AFTER

SNF/HH Provider: _____ Phone: _____

I certify that this plan of treatment is medically necessary.

Doctor's Signature: _____ Date: _____

Doctor's Name: _____ Phone: _____

NPI#: _____