Medical Referral Form
Powerhouse Therapy
4650 Glenforest Dr. NE
Roswell, GA 30075

Referral for services: Powerhouse Therapy Constraint-Induced Therapy program. I have reviewed the medical records of

_____,
(Child's Name)

and agree that it is safe for him/her to participate in Pediatric Constraint-Induced Therapy. This referral is for Occupational Therapy, Physical Therapy, and Constraint casting.

_____
PRINT NAME OF PHYSICIAN

_____
ADDRESS OF PHYSICIAN

_____
PHYSICIAN'S PHONE

_____ _____
SIGNATURE OF PHYSICIAN DATE

_____ _____
SIGNATURE OF PARENT DATE

_____
DIAGNOSIS