POWERHOUSE THERAPY

# MEDICAL REFERRAL FORM

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

Name of Child

Name of Physician _____

Address _____

City _____ State_____ Zip Code _____

Cell/work phone: _____

_____ _____

SIGNATURE OF PHYSICIAN DATE

_____ _____

SIGNATURE OF PARENT DATE

_____

DIAGNOSIS

**PLEASE MAIL TO** Powerhouse Therapy, 1525 Haven Crest Drive, Powder Springs, GA 30127

**FAX** 1-866-430-3367 **EMAIL** info@constrainttherapy