Rutland Regional Medical Center
Rehabilitation Services

Outpatient Rehabilitation Services
Referral Form

T: 802.747.1840
F: 802.747.3856

***Patient Name:** _____ ***Patient Date of Birth:** _____

Telephone: _____ ***Referring Provider**: _____
(Please Print) (Credentials MD, DO, NP, PA, other)

***Diagnosis**: _____

Schedule Appointment with: ◯ Patient ◯ Parent ◯ Caregiver/Guardian ◯ Other _____

Caregiver/Guardian: _____ Telephone: _____

Traumatic Brain Injury Program

☐ PT ☐ OT ☐ SLP

Stroke Program

☐ PT ☐ OT ☐ SLP

☐ Prosthetic/Orthotic Clinic

☐ Advanced IADL

☐ Hand Therapy

☐ Lymphedema Program

☐ Occupational Therapy (OT) Evaluation/Treatment

☐ Physical Therapy (PT) Evaluation/Treatment

☐ Speech/Language Pathology (SLP) Evaluation/Treatment

☐ Videofluoroscopic Swallow Study/Modified Barium Swallow

☐ Balance Rehabilitation Program

☐ Wheelchair & Seating Clinic

☐ Functional Capacity Evaluation

Special Instructions:

***Provider Signature:** _____ *** Date:** _____

*** Required Elements for a Valid Referral**

Office notes related to the visit that generated the referral are helpful in scheduling the initial appointment.

For expedited scheduling, please fax this completed referral to 802.747.3856