

Physical Therapy / Occupational Therapy REFERRAL

Patient Name: _____

Reason for Referral: _____

Special Programs & Services:

Evaluation & Treatment

Therapeutic Exercise

Massage Therapy

Manual Therapy

Total Knee Replacement Protocol

Rotator Cuff Repair Protocol

One Time Evaluation & Home Exercise Program

Onsite Home Safety Assessment

Worksite Ergonomic Assessment

I CERTIFY THAT THESE SERVICES ARE MEDICALLY NECESSARY.

Physician Signature:

Date:

Referring Physician Name (PRINTED)

Treatment Locations:

Onsite - In your patient's home, office, or other location

Middletown Clinic - 5900 Long Meadow Dr, Middletown, OH 45005

Monroe Clinic - 20 Overbrook Dr Ste D, Monroe, OH 45050

Distribution Planner:

Referral Sources - 12

January - Mail 3 pads to source 1, 2, 3

Feb - Mail 3 pads to source 4, 5, 6

Mar - Mail 3 pads to source 7, 8, 9

April - Mail 3 pads to source 10, 11, 12

Repeat the cycle x3 rounds.

After 12 months replace non referring referral sources.

How do you send referral pads?

Large format envelope

Addressed to specific physician

Cover letter introducing yourself and business model.

Hello Dr. Smith,

I am Anthony Maritato, P,T physical therapist, and I am including three referral pads for a new physical therapy service available to your patients in Middletown, OH.

Medicare and other third party payers allow outpatient physical therapy services to be provided in a brick and mortar clinic as well as in the patient's home. Since many post operative patients are unable to drive, I am providing in-home services until the patient is ready to start outpatient physical therapy.

These in-home services are not home health and do not require the patient be **HOMEBOUND**.

I am a participating Medicare provider and most Medicare these services are fully covered for most Medicare beneficiaries.

Thank you for your time,

Sincerely,

Anthony Maritato, PT
Total Therapy Solutions LLC