

**Inpatient Physical Rehabilitation Referral**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Contact Information­:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide copies of the following:

* Recent H&P
* Recent lab results
* Home Status: Lives alone, with spouse, Home, Assisted Living
* Copy if insurance cards
* Medical restrictions
* Recent home health or outpatient therapy notes

**Referrals will be contacted by a clinical liaison and assessed for admission by the Medical Director for Inpatient Rehabilitation.**

Thank you for your consideration,

Inpatient Rehabilitation Unit

Phone: 316-804-6203

Fax: 316-804-6260

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