Secure Fax – 888-624-3107   Phone: 507-259-7570

Non-Medical Provider Referral Form

Patient Name: ______________________________________ Hospital Clinic # _____________

Date of Birth: ___________ Phone number: _________________

Primary insurance: ____ # if available ____________

Address: ____

Primary Medical Provider Name: ________________________________ Mayo or Olmsted

Service recommended:

____ Physical Therapy (No MD order Required)

____ Occupational Therapy (No MD order Required)

____ Medical Nutrition Therapy – Dietician (Must have MD order for this)

____ Forever Strong (245D ILS (CADI) and Specialist Services (DD) Life Wellness Program)

- The medical conditions that supports the need for the above services are:
  ____
  ____
  ____

I am referring this client for therapy services

______ In their home

______ For aquatic therapy

______ To be seen at Exercisabilities clinic

______ I certify that the above is not currently receiving any home care services that qualify for Medicare Part A services and would like them to be seen under Medicare B, commercial insurance, or private pay means.

Referral source Name: ______________________ Phone: __________Fax:_______________

We do not require any other referral forms or information. We can call and set up the visit with the client and verify all insurances. We appreciate your referral!