



North Central Health Care

Person centered. Outcome focused.

PHYSICIAN REFERRAL FOR AQUATIC SERVICES

Aquatic Physical Therapy: 715.848.4551 | Fax 715.841.5187 | AquaticTherapy@norcen.org

Please fully complete the form below and return to Aquatic Services via fax or email.

PART I: PARTICIPANT COMPLETES (PLEASE PRINT)

Name: _____ Date of Birth: _____

Address: _____ Telephone: _____

City, State, Zip: _____ Cell Phone: _____

Emergency Contact: Name: _____ Telephone: _____

Address: _____

Participant Signature _____ Date: _____

PART II: AQUATIC SERVICES OFFERED AT NORTH CENTRAL HEALTH CARE

Please check which program you would like to participate in:

Aquatic Physical Therapy: One on one treatment with a licensed physical therapist.

Open Aquatic Exercises: Independent pool time for individuals to exercise without a Fitness Instructor or Physical Therapist.

ALL Aquatic Physical Therapy referrals MUST have a diagnosis and "Eval and Treat" written.

Medical Diagnosis: _____

ICD 10 Code: _____

I agree that this patient is continent and able to participate in Aquatic Services.

Doctors Name PRINT: _____ Phone Number: _____

Doctor's Signature: _____ Date: _____