

1100 Lake View Drive, Wausau, WI 54403-6799

PHYSICIAN'S REFERRAL FOR AQUATIC SERVICES

Contact Phone: 715.848.4551 or 715.848.4535 Fax Number: 715.841.5187

Please **PRINT** the requested information below in its entirety. Return form to Aquatic Services.

PART I: PARTICIPANT COMPLETE

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____ TELEPHONE: _____

EMERGENCY CONTACT: NAME: _____ TELEPHONE: _____

ADDRESS: _____

I understand that I will be participating in Aquatic Services.

(Participant Signature)

(Date)

PART II: Types of Aquatic Services offered at North Central Health Care

NOTE TO DOCTOR: ALL AQUATIC PHYSICAL THERAPY REFERRALS MUST HAVE A DIAGNOSIS AND "EVAL AND TREAT" WRITTEN.

AQUATIC PHYSICAL THERAPY: One on one treatment, twice a week with a licensed physical therapist.

ARTHRITIS EXERCISE CLASS: Arthritis Foundation certified; gentle range of motion for joints with some walking exercises.

AQUA FITT EXERCISE CLASS: Rigorous exercise level, participate at your own pace. Must be able to walk across pool independently.

COMMUNITY & FAMILY FITT: Unstructured, participant benefits from warm water.

PLEASE CIRCLE WHICH PROGRAM YOU WOULD LIKE TO PARTICIPATE IN

AQUATIC PHYSICAL THERAPY

EXERCISE CLASSES

COMMUNITY FITT

MEDICAL DIAGNOSIS: _____

ICD 10 CODE: _____

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

(Doctor's name, PLEASE PRINT)

(Doctor's Telephone)

(Doctor's Signature)

(Date)