GROUNDSWELL MFR

Service recipient name: (please print) _____

Date of birth: _____

Parent(s) and/or Legal guardian(s) name(s): _____

_____ _____

Address: _____

Phone: _____

Email: _____

Medical Diagnosis: _____

Symptom(s): _____

Precaution(s)/Restriction(s): _____

Occupational Therapy skilled interventions include:

- Occupational Therapy Evaluation and Treatment (as indicated, i.e as needed, i.e. PRN)
- Myofascial Release (MFR) treatment / Manual therapy / Therapeutic activity
- Therapeutic exercise
- Neuromuscular reeducation
- Home program / Patient and Caregiver education and training

Frequency and Duration to be determined by evaluation and assessment findings, treatment response, therapist's clinical judgement, and agreement/permission from service recipient and/or parent(s) and/or legal guardian(s).

GROUNDSWELL MFR

Referral Signature: _____ Date: _____
Referral Name: _____

Occupational Therapist signature: _____
Occupational Therapist name: jeff TATLONGHARI
Occupational Therapist State of Tennessee License #0000007116 Business Name: Groundswell MFR, LLC