North Central Health Care
Person centered. Outcome focused.

1100 Lake View Drive, Wausau, WI 54403-6799

PHYSCIAN'S REFERRAL FOR AQUATIC SERVICES

Phone: 715.848.4551 or **715.848.4535** **Please Return Form by Fax: 715.841.5187** or **Email: AquaticTherapy@norcen.org**

Please **PRINT** the requested information below it its entirety. Return form to Aquatic Services via fax or email above.

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)