



PLEASE COMPLETE AND FAX

- 651-229-3911 Gillette Main Campus – St. Paul, MN
- 952-223-3405 Gillette Burnsville Clinic – Burnsville, MN
- 952-936-0944 Gillette Minnetonka Clinic – Minnetonka, MN
- 651-638-4744 Gillette Lifetime Specialty Healthcare – St. Paul, MN
- 763-496-6660 Gillette Maple Grove Clinic – Maple Grove, MN

PHYSICIAN ORDER FOR THERAPY SERVICES

Patient Name _____ Date of Birth _____
Treatment Diagnosis _____ Date of Onset _____
Parent/Guardian _____ Phone Number _____
Precautions/Contraindications (none unless specified) _____
Interpreter Needed: No Yes: Language: _____

For More Information

- New Patient Services: 651-290-8707
- Scheduling: 651-290-8707
- Therapy Information: 651-229-3905
(Rehabilitation Therapies Manager)

Preferred Service Location:

- Gillette Main Campus –200 University Ave E, St. Paul, MN 55101
- Gillette Minnetonka Clinic – 6060 Clearwater Dr., Minnetonka, MN 55343
- Gillette Burnsville Clinic – 305 East Nicollet Blvd., Burnsville, MN 55337
- Gillette Lifetime (16 and older) – 435 Phalen Blvd., St. Paul, MN 55130
- Gillette Maple Grove –9550 Upland Ln N., Maple Grove, MN 55369

Physical Therapy

Reason for Referral _____

- _ Evaluation only (assess and make recommendations)
- _ Evaluation and treatment (assess status, make recommendations and develop care plan; state frequency and duration below)
 - _ Frequency of treatment (number of times per week) _____
 - _ Duration of treatment will be through recertification unless otherwise stated _____
(Outpatients are recertified at least every 60 days)

Comments: _____

Occupational Therapy

Reason for Referral _____

- _ Evaluation only (assess and make recommendations)
- _ Evaluation and treatment (assess status, make recommendations and develop care plan; state frequency and duration below)
 - _ Frequency of treatment (number of times per week) _____
 - _ Duration of treatment will be through recertification unless otherwise stated _____
(Outpatients are recertified at least every 60 days)

Comments: _____

Speech and Language Pathology

Reason for Referral _____

- _ Evaluation only (assess and make recommendations)
- _ Evaluation and treatment (assess status, make recommendations and develop care plan; state frequency and duration below)
 - _ Frequency of treatment (number of times per week) _____
 - _ Duration of treatment will be through recertification unless otherwise stated _____
(Outpatients are recertified at least every 60 days)

Comments: _____

Physician Name (Print) _____ Physician Signature _____ Date _____
Physician Phone _____ Address _____