



JaySTART Clinic

(Student Teaching and Rehabilitation Training)
PT/OT/SLP Referral Form

By appointment only

Kirmayer Fitness Center
2141 Olathe Blvd, Kansas City, KS 66103

Scheduling/Referral/Communication email:
JaySTART@kumc.edu

Patient Name: _____ **Date:** _____ **Date of Birth:** _____
Patient Phone (used to schedule): #1: _____ #2: _____

Preferred language: _____ **Patient email:** _____
Diagnosis: _____ **Level of Urgency:** low medium high

Preference (circle one or both):

Telehealth (virtual via protected Zoom) and/or In-person at Kirmayer (subject to availability)

Circle the appropriate prescription:

- Evaluate and Treat PT/OT
- Evaluate and Treat SLP
- Evaluate and treat PT/OT/SLP
- Other – please indicate _____

Precautions or contraindications specific to physical therapy/occupational therapy/speech therapy (i.e., pacemaker, insulin dependent) or **relevant medical history** or **other helpful information** (i.e., history of knee replacement)?

Referring Clinic: _____ **Clinic Phone:** _____
Referring Provider Name: _____

Would you like a copy of the notes to be sent to you? (Yes / No):

Send report to: _____
Secure email: _____
Secure fax: _____