

PHYSICAL THERAPY REFERRAL

Date: _____

Patient Name: _____

DOB: _____ Phone: _____

Diagnosis: _____

<input type="checkbox"/> Evaluate and Treat <input type="checkbox"/> _____ times per week for _____ weeks
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Precautions/Instructions: _____

Therapy Procedures and Special Programs

- | | |
|--|---|
| <input type="checkbox"/> Therapeutic Exercise
<input type="checkbox"/> Home Program | <input type="checkbox"/> Neuromuscular Re-education
<input type="checkbox"/> Balance/falls |
| <input type="checkbox"/> Modalities
<input type="checkbox"/> EStim
<input type="checkbox"/> Iontophoresis | <input type="checkbox"/> Functional Activities
<input type="checkbox"/> Gait
<input type="checkbox"/> Transfers |
| <input type="checkbox"/> Manual Therapy
<input type="checkbox"/> Joint Mobilization
<input type="checkbox"/> Joint Manipulation
<input type="checkbox"/> Soft tissue mobilization
<input type="checkbox"/> Scar tissue massage | <input type="checkbox"/> Mechanical Traction
<input type="checkbox"/> Back Program
<input type="checkbox"/> Cervical Headaches
<input type="checkbox"/> Dry Needling |
| <input type="checkbox"/> Post-Op Protocol
Date of Surgery _____ | <input type="checkbox"/> Pediatrics
<input type="checkbox"/> Post-Concussion |

Signature _____ Date: _____