

Tel :

Fax :

## PHYSICAL THERAPY REFERRAL ORDER

PATIENT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ DOB: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

SURGICAL PROCEDURE/DATE: \_\_\_\_\_

COMMENTS/PRECAUTIONS: \_\_\_\_\_

|                      |                                 |            |       |        |
|----------------------|---------------------------------|------------|-------|--------|
| <b>Instructions:</b> | Evaluate and Treat              | Report by: | Fax   | Letter |
| Treatment Plan       | And/Or Specify Treatment below: |            |       |        |
| Frequency/Duration:  | _____ /Week                     | For        | _____ |        |

|                    |               |               |                            |                  |
|--------------------|---------------|---------------|----------------------------|------------------|
| <b>Modalities:</b> | Cold          | Heat          | Electrical Stimulation     | TENS/Instruction |
| US                 | Phonophoresis | Iontophoresis | Manual/Mechanical Traction |                  |

|                    |                                |  |                      |  |
|--------------------|--------------------------------|--|----------------------|--|
| <b>Procedures:</b> | Manual Therapy/Soft Tissue Mob | Functional Activities/Individual Instruction |                      |  |
| Joint Mobilization | ROM/Flexibility                | Strengthening                                | Therapeutic Exercise |  |
|                    | Core Stability                 | Gait Training                                |                      |  |

|                        |                            |                      |          |
|------------------------|----------------------------|----------------------|----------|
| <b>Other Services:</b> | Egonometric Evaluation     | Work Site Assessment | Aquatics |
|                        | Physical Abilities Testing | Work Conditioning    |          |

**Additional Comments:** \_\_\_\_\_

**Physicians Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Physicians Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_