Physical Therapy Referral

Name _____ D.O.B _____ Date _____

Phone Number _____ Email _____

Diagnosis _____ Body Part _____ ICD Code _____

Surgery/Injury Date _____ Precautions/Contraindications/Imaging _____

Suggested Modalities/Procedures (check applicable)

- ☐ Evaluation & Treatment

Manual Techniques

- ☐ Soft Tissue Mobilization
- ☐ Joint Mobilization
- ☐ Assisted Stretching

Thermal Modalities

- ☐ Hot/Cold Packs
- ☐ Ultrasound

Pain/Inflammation Reducing Modalities

- ☐ Electrical Stimulation
- ☐ Iontophoresis
- ☐ Phonophoresis

Therapeutic Exercise

- ☐ Post-Op Progression
- ☐ Open Chain
- ☐ Closed Chain
- ☐ Trunk Stabilization
- ☐ Water Based
- ☐ Home Program
- ☐ Gym Program
- ☐ Return to Sport
- ☐ Work conditioning
- ☐ Pre-Op Instruction
- ☐ Body Mechanics/Posture Training
- ☐ Gait Training
- ☐ On Site Ergonomic Analysis/Recommendations
- ☐ Foot Orthotics
- ☐ Other Instructions/Information

Comments/Instructions _____

Frequency _____ Duration _____ Total Visits _____

Physician Signature _____ Date _____

Next Scheduled Follow Up _____

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