Restorative Therapy & Wellness LLC

We restore your movement

Physical Therapy Referral

Patient Name _____

Patient Phone _____

Diagnosis _____

❑ **Physical Therapy** ❑ **Evaluate and Treat**

- ❑ Duration up to _____ times per week for ____ weeks
- ❑ Precautions _____

Procedures

- ❑ AROM/ AAROM/ PROM/ RROM
- ❑ Gait and Balance Training
- ❑ Neuromuscular Re-ed
- ❑ Self-care/Home management
- ❑ Soft Tissue/ Joint Mobilization
- ❑ Spine Stabilization
- ❑ Therapeutic Exercises
- ❑ Vestibular Rehab

Modalities

- ❑ Heat/ Ice
- ❑ Electrical Stimulation
- ❑ Lumbar/ Cervical Traction
- ❑ Ultrasound
- ❑ Phonophoresis
- ❑ Iontophoresis

Other _____

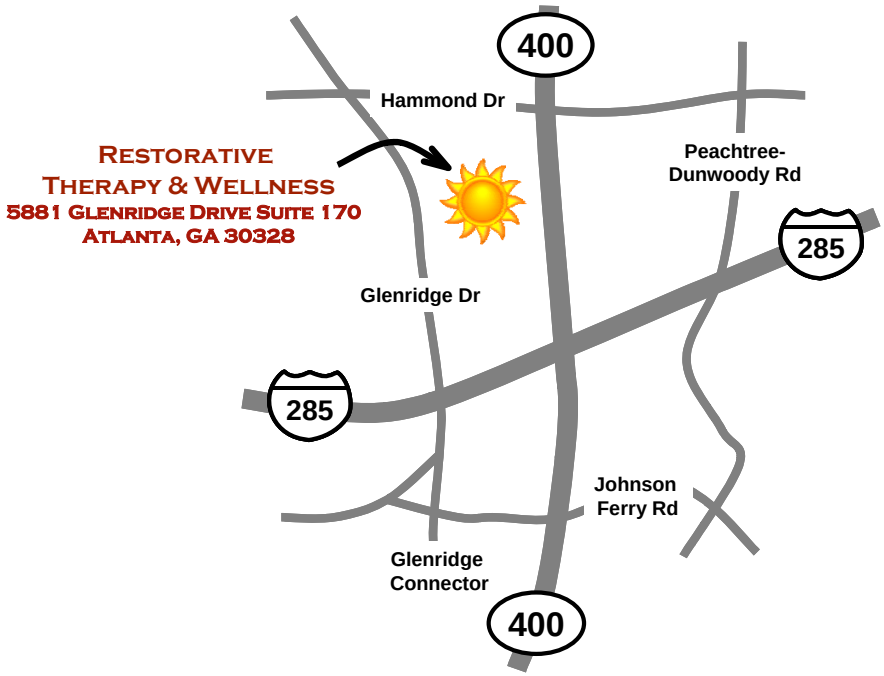
_____

Physician Name _____

Signature _____ **Date** _____

Call to schedule. Bring this referral with you to appointment.

5881 Glenridge Drive Suite 170 Atlanta, GA 30328
404-236-0934 (phone) 404-236-0935 (fax)



Patient Instructions:

1) Bring photo ID and current insurance card

2) Wear or bring loose-fitted exercise clothing, such as gym shorts, tank top or t-shirt and athletic shoes

3) Please arrive 15-30 minutes early for your first appointment in order to complete paperwork

We look forward to restoring your movement through personalized, individual care.