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

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**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

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