**Diagram

Description automatically generated**

**Physical Therapy Referral**

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Evaluate and Treat as Indicated\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight Bearing Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Frequency: (Circle) | Daily | | 2x/Week | | 3x/Week | | Other: \_\_\_\_\_\_\_\_ | | | Duration: \_\_\_\_\_\_\_\_\_\_\_ | |
|  |  | |  | |  | |  | |  | | |
| Hydrotherapy | | Therapeutic Exercises | | | | Manual Therapies | | | | | Home Units | |
| Hot Packs | | Passive Range | | | | Joint Mobilization | | | | | Cervical Traction | |
| Cold Packs/Cryotherapy | | Active | | | | Soft Tissue Mobilization | | | | | Lumbar Traction | |
| Paraffin Bath | | Isometric | | | | NMES/TENS | |
|  | | Progressive Resistive | | | | Dry Needling | | | | | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | |  | | | |  | | | | |  | |
| Modalities | | | | Therapeutic Activity | | | | Goals | | | | |
| Electrical Stimulation | | | | Gait Training | | | | Decrease Pain | | | | |
| Iontophoresis | | | | Balance Training | | | | Decrease Edema | | | | |
| Traction | | | | Run/Jump Program | | | | Increase ROM | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_ lbs. | | | | Thrower’s Program | | | | Increase Strength | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_ Lumbar | | | | LSVT BIG | | | | Increase Function | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cervical | | | | Vestibular | | | | Increase Posture | | | | |
|  | | | |  | | | |  | | | | |

Special Instructions/Precautions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the above services are required and authorized by me:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature Date