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**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