Physical Therapy Referral

Name:_____ Date:_____

Diagnosis: _____ Precautions:_____

□ 2-3 times per week _____ weeks

□ Evaluate & Treat As Appropriate □ Non-weight Bearing

□ Therapeutic Exercise
- □ Passive ROM
- □ Active ROM
- □ Strengthening
- □ Stretching/ Flexibility
- □ Home Exercise Program

□ Manual Therapy Techniques

□ Neuromuscular Reeducation (Balance, Posture, Body Mechanics, Coordination).

□ Lumbar & Cervical Stabilization Exercise

□ Low Back & Neck Pain

□ Vestibular Rehabilitation

□ Balance Training

□ Gait Training

□ Posture/ Body Mechanics

□ Cardiac Rehabilitation

□ Modalities
- □ Moist Heat
- □ Cryotherapy/ ICE
- □ Electrical Stimulation
- □ Ultrasound
- □ Phonophoresis
- □ Iontophoreses
- □ Paraffin

Physician's Name (Print): _____ Physician's Signature: _____

NPI Number: _____

Date: _____