



## Physical Therapy Referral

Name \_\_\_\_\_ D.O.B \_\_\_\_\_ Date \_\_\_\_\_

Phone Number \_\_\_\_\_ Email \_\_\_\_\_

Diagnosis \_\_\_\_\_ Body Part \_\_\_\_\_ ICD Code \_\_\_\_\_

Surgery/Injury Date \_\_\_\_\_ Precautions/Contraindications/Imaging \_\_\_\_\_

**Suggested Modalities/Procedures** (check applicable)

Evaluation & Treatment

**Manual Techniques**

Soft Tissue Mobilization

Joint Mobilization

Assisted Stretching

**Thermal Modalities**

Hot/Cold Packs

Ultrasound

**Pain/Inflammation Reducing Modalities**

Electrical Stimulation

Iontophoresis

Phonophoresis

**Therapeutic Exercise**

Post-Op Progression

Open Chain

Closed Chain

Trunk Stabilization

Water Based

Home Program

Gym Program

Return to Sport

Work conditioning

Pre-Op Instruction

Body Mechanics/Posture Training

Gait Training

On Site Ergonomic Analysis/Recommendations

Foot Orthotics

Other Instructions/Information

Comments/Instructions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Frequency \_\_\_\_\_ Duration \_\_\_\_\_ Total Visits \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Next Scheduled Follow Up \_\_\_\_\_