



## Physical Therapy Referral

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

Diagnosis: \_\_\_\_\_

- |                                                         |                                                           |
|---------------------------------------------------------|-----------------------------------------------------------|
| <input type="checkbox"/> <b>Evaluate and Treat</b>      | <input type="checkbox"/> Posture/Body Mechanics Education |
| <input type="checkbox"/> Biomechanical Assessment       | <input type="checkbox"/> Cold/Moist Heat                  |
| <input type="checkbox"/> Gait/Balance Training          | <input type="checkbox"/> Electrical Stimulation/TENS/IFC  |
| <input type="checkbox"/> PROM/AAROM/AROM                | <input type="checkbox"/> Ultrasound                       |
| <input type="checkbox"/> Splinting/Orthotic Fabrication | <input type="checkbox"/> Home Exercise Program            |
| <input type="checkbox"/> Stretching/Mobilization        | <input type="checkbox"/> Healthy Lifestyle Assessment     |
| <input type="checkbox"/> Therapeutic Exercise           | <input type="checkbox"/> Weight Loss Program              |
| <input type="checkbox"/> Decompression Traction         | <input type="checkbox"/> Medical Membership               |

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_



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