



Physical Therapy Referral

Patient Name _____ Date _____

Diagnosis _____

Date of Injury _____ Claim # _____

Date of Surgery _____

Precautions / Contraindications _____

Date of patient's follow up appointment _____

TREATMENT:

- Evaluation and Treatment at Therapist's Discretion
 Report by Phone Report by Letter

- Procedures:**
- | | |
|---|---|
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Joint Mobilization |
| <input type="checkbox"/> AROM/PROM | <input type="checkbox"/> Soft Tissue Mobilization |
| <input type="checkbox"/> Gait Training | <input type="checkbox"/> Traction |

- Modalities:**
- | | |
|--|---|
| <input type="checkbox"/> Ultrasound | <input type="checkbox"/> Moist heat |
| <input type="checkbox"/> Cryotherapy | <input type="checkbox"/> Muscle Stimulation |
| <input type="checkbox"/> Interferential Stimulation | <input type="checkbox"/> Phonophoresis |
| <input type="checkbox"/> Additional Treatment Instructions _____ | |

PLAN:

Frequency/Duration 1 2 3 4 5 times per week for _____ weeks.

Additional Comments _____

Practitioner's Signature _____

Thank you for this referral.



NORTH

Interstate 5

Continental Place

East College Way

Roosevelt Ave

Parker Way

Jay Way

18th St

Food Pavillion

Roosevelt
Professional
Center

Valley Rehab

Physical Therapy

1600 Roosevelt Ave, Suite B

360-424-5215

