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PHYSICAL THERAPY REFERRAL

Patient Name Date of Birth

Patient's Telephone Number

Diagnosis

Special Instructions/Precautions

Frequency:_____times per week for_____weeks.

TREATMENT PROCEDURES

Δ EVALUATE AND TREAT	Δ CORE/SPINE STABILIZATION	Δ NECK/BACK PAIN
Δ MANUAL THERAPY	Δ SELF/HOME MANAGEMENT	Δ ERGONOMIC ANALYSIS
Δ KNEE/ACL REHAB	Δ FALL PREVENTION	Δ POST-OP/PRE-OP
Δ FOOT PAIN/HEEL PAIN	Δ CONTINUE THERAPY	Δ GOLF INJURY PREVENTION
Δ ADHESIVE CAPSULITIS	Δ WORK CONDITIONING	Δ HIP PAIN/BURSITIS/ITB
Δ TENNIS/GOLFER'S ELBOW	Δ SHOULDER IMPINGEMENT	Δ BALANCE TRAINING
Δ JOINT ARTHROPLASTY	Δ ACL INJURY PREVENTION	Δ TMJ

As the referring practitioner, I hereby certify that the above services are medically necessary.

SIGNATURE **DATE**