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Physical Therapy Referral Form

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Patient Phone: _____ [] Please call Patient [] Patient will call to schedule
ICD 9 Code: _____ Authorization #: _____
Diagnosis: _____
Date of Surgery _____ Date of Injury _____

ORDER

Precautions: _____

Frequency: _____ days/week for _____ weeks

Physical Therapy

- ☐ Evaluation and treatment
- ☐ Therapeutic Exercise (Active, Passive)
- ☐ Functional Activities (Gait, Balance, ADL)
- ☐ Neuromuscular Re-education
- ☐ Manual Therapy (Joint & Soft Tissue Mobilization)
- ☐ Modalities (Elect Stim, Ultrasound, Lontophoresis)
- ☐ Thermal Modalities (Ice, Moist Heat)
- ☐ Traction (Lumbar, Cervical)

Specialty Programs

- ☐ General Exercise for Health
- ☐ Arthritis and Rehabilitation
- ☐ Balance /Fall Prevention
- ☐ Low Back and Neck Pain
- ☐ Osteoporosis Program
- ☐ Post-Surgical Care
- ☐ Work Injury / Return to Work

☐ Occupational Rehabilitation

☐ Comments: _____

Zhinian Wan, M.D.
Printed Name

Signature

Date: _____