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Outpatient Physical Therapy Referral Form

Patient Name: _____ Date: _____

Diagnosis: _____

Precautions/Contraindications: _____

Frequency: _____ Duration: _____

Treatment Recommendations

- | | |
|--|--|
| <input type="checkbox"/> Evaluation & Treatment | <input type="checkbox"/> Neuromuscular Re-Education |
| <input type="checkbox"/> Therapeutic & Home Exercise Instruction | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Spine Rehabilitation | <input type="checkbox"/> Phonophoresis/Iontophoresis |
| <input type="checkbox"/> Sports Rehabilitation | <input type="checkbox"/> Massage/Myofascial Release |
| <input type="checkbox"/> Arthritis Program | <input type="checkbox"/> Electrical Stimulations/TENS/NMES |
| <input type="checkbox"/> Aquatic Physical Therapy | <input type="checkbox"/> Manual Traction |
| <input type="checkbox"/> Fibromyalgia Program | <input type="checkbox"/> Work Site/Ergonomic Analysis |
| <input type="checkbox"/> Neurological Rehabilitation | <input type="checkbox"/> ADL Retraining |
| <input type="checkbox"/> Balance Rehabilitation | <input type="checkbox"/> Pre-Operative Education |
| <input type="checkbox"/> Vestibular Rehabilitation | <input type="checkbox"/> Breast Cancer Recovery Program |
| <input type="checkbox"/> Osteoporosis Management | <input type="checkbox"/> Wound Care Program |
| <input type="checkbox"/> Pelvic Floor Rehabilitation | <input type="checkbox"/> Stroke Rehabilitation |
| <input type="checkbox"/> Gait Training | <input type="checkbox"/> Cardiac Rehabilitation |
| <input type="checkbox"/> Pediatric Therapy Services | <input type="checkbox"/> Plyometrics Exercise Program |
| <input type="checkbox"/> Total Joint Replacement | <input type="checkbox"/> Long-Term Exercise Program |

Comments: _____

Signature: _____ Printed Name: _____

PIN # _____ Office Phone: _____