Physical Therapy Referral Form

Patient Name: _____

Patient Phone#:_____

Diagnosis: _____

CPT Code: _____

MD Follow up Appt: _____ Today's Date: _____

☐ Evaluate and treat as appropriate

- ☐ Manual Therapy
  - ☐ Soft Tissue Mobilization
  - ☐ Joint Mobilization
  - ☐ Joint Manipulation
  - ☐ Functional Dry Needling
  - ☐ Myofascial Release
- ☐ Neuromuscular Re-education
- ☐ Balance Program
- ☐ Gait Training: Weight Bearing Status:_____
- ☐ Therapeutic Exercise
  - ☐ Range of Motion
    - ☐ Active
    - ☐ Active Assisted
    - ☐ Passive
- ☐ Strengthening
- ☐ Core Stabilization
- ☐ Spinal Stabilization
- ☐ Stretching

Treatment Frequency (days per week): ___1 ___2 ___3

Treatment duration (weeks): ___1 ___2 ___3 ___4 ___5 ___6

Precautions: _____

Contraindications:_____

Physician Signature:_____

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Thank you for your referral!