



SPINAL HEALTH & REHAB

Physician Referral for Physical Therapy

Patient Name: _____ DOB: _____

Patient phone #: _____ ICD-10 code: _____

Diagnosis: _____

Surgical Procedures: _____

PHYSICAL THERAPY

- | | | |
|---|---|---|
| <input type="checkbox"/> Evaluate and Treat | <input type="checkbox"/> Therapeutic Exercises | <input type="checkbox"/> Strengthening |
| <input type="checkbox"/> Stretching | <input type="checkbox"/> Isometrics | <input type="checkbox"/> AROM |
| <input type="checkbox"/> AAROM | <input type="checkbox"/> PROM | <input type="checkbox"/> Gait Training |
| <input type="checkbox"/> Postural Training | <input type="checkbox"/> Joint Mobilization | <input type="checkbox"/> Myofascial Release |
| <input type="checkbox"/> PRN Modalities | <input type="checkbox"/> Electrical Stimulation | <input type="checkbox"/> Hot Pack |
| <input type="checkbox"/> Cold Pack | <input type="checkbox"/> Home Exercise Program | |
| <input type="checkbox"/> Other: _____ | | |

Frequency: 1X 2X 3X 4X 5X Daily

Duration: 2 weeks 3 weeks 4 weeks 5 weeks 6 weeks 8 weeks

SPECIALTIES

- Physical Therapy Chiropractic

Physician certifies that the prescribed therapy is of medical necessity.

Notes/Special Instructions: _____

Physician Name (Printed): _____

Physician Signature: _____ Date: _____

Physician Phone #: _____