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## PHYSICAL THERAPY PRESCRIPTION/REFERRAL

### SERVICE LOCATION:

IN CLINIC     IN PATIENT HOME     AT PATIENT DISCRETION

Patient: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Provider: \_\_\_\_\_ Date: \_\_\_\_\_

#### Order for:

PHYSICAL THERAPY EVAL AND TREAT

CONTINUATION OF THERAPY FOR \_\_\_\_\_ (duration)

Duration: (If specified)

TIMES PER WEEK FOR \_\_\_\_\_ WEEKS

#### Limitations/Restrictions/Precautions:

#### Weight Bearing Restrictions (please note if applicable)

No Restrictions    WBAT % \_\_\_\_\_    TTWB \_\_\_\_\_    NWB \_\_\_\_\_

#### INTERVENTIONS:

Please circle for specific request/order IF INDICATED, otherwise Eval/Treat meets requirements

AROM/AAROM/PROM

GAIT TRAINING

VESTIBULAR REHAB

MANUAL THERAPY

NEURO REHAB

SPORT SPECIFIC REHAB

MODALITIES

STRENGTHENING

PELVIC FLOOR THERAPY

COLD/HOT PACKS

ULTRASOUND

HOME EXERCISE PROG.

DRY NEEDLING

E-STIM

LASER

BALANCE TRAINING/

KINESIOTAPING

FALL RISK REDUCTION

OTHER: \_\_\_\_\_

PROVIDER SIGNATURE \_\_\_\_\_

DATE: \_\_\_\_\_

**THANKS FOR THE REFERRAL!**

**Please include patient demographics with referral.**