NORTH PLATTE PHYSICAL THERAPY

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PHYSICAL / OCCUPATIONAL THERAPY REFERRAL

Patient's Name: Date of Birth:

Address:

Diagnosis:

Referring Physician: Code:

Onset Date: Patient Aware of Dx: X Yes No

TREATMENT DESIRED

X Evaluate and Treat	XTherapeutic Exercise	X Manual Therapy
X Modalities	X AROM	X Soft Tissue
X Hot/Cold Pack	X PROM	X Joint Mobilization
X Ultrasound/Phonophoresis	X Strengthening	X Other
X Electrical Stimulation	X Stretching	X Graston/ASTYM/IAMT
TENS	Pool	Hand Program
Iontophoresis	Gait Training	Splint/Orthotic Fabrication
Paraffin/ X Cupping	Lifting/Posture Instruction	Functional Capacity Evaluation
Traction	Home Exercise Program	Work Site Evaluation
X Functional Dry Needling	X Strapping / Kinesiotape	Work Hardening/ Conditioning

Special Instructions: N/A

Pt discharge: N/A Discharge Date: N/A

Reason for discharge: N/A

Frequency: 2-3X PER WEEK Duration: 4 WEEKS

Goals: DECREASE PAIN, INCREASE ROM AND STRENGTH TO IMPROVE FUNCTION.

Precautions: PER PROTOCOL

Effective Date: Signature: Date: