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PHYSICAL/OCCUPATIONAL THERAPY REFERRAL

Patient's Name ____ Date of Birth ____________

Address ____ Phone _________________

Diagnosis ____

Referring Physician ____Code __________________

Onset Date ___________________________________ Patient Aware of DX ______ Yes _______ No

____ Evaluate and Treat

____ Modalities

____ Hot/Cold Packs

____ Ultrasound/Phonophoresis

____ Electrical Stimulation

____ TENS

____ Iontophoresis

____ Traction

____ Therapeutic Exercise

____ AROM

____ PROM

____ Strengthening

____ Stretching

____ Gait Training

____ Lifting/Posture Instruction

____ Home Exercise Program

____ Manual Therapy

____ Soft Tissue

____ Joint Mobilization

____ Splint/Orthotic Fabrication

____ Functional Capacity Evaluation

____ Work Site Evaluation

____ Work hardening

Special Instructions ____

____

Frequency ___________________________________ Duration _______________________________

Goals ____

Precautions ____

Date ____________________ Signature X____