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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 ________ yes ________ no

TREATMENT DESIRED

_____Evaluate and Treat
_____Modalities
    _____Hot/Cold Pack
    _____Ultrasound/Phonophoresis
    _____Electrical Stimulation
    _____TENS
    _____Iontophoresis
    _____Parafin
_____Traction

_____Therapeutic Exercise
    _____AROM
    _____PROM
    _____Strengthening
    _____Stretching
    _____Pool
    _____Gait Training
    _____Lifting/Posture Instruction
_____Home Exercise Program

_____Manual Therapy
    _____Soft Tissue
    _____Joint Mobilization
    _____Other
_____Hand Program
_____Splint/Orthotic Fabrication
_____Functional Capacity Evaluation
_____Work Site Evaluation
_____Work Hardening/Conditioning

Special Instructions ____

____

Discharge Date ______________________________

Frequency ______________________ Duration ______________________

Goals ____

Precautions ____

Date ______________________ Signature **X** ______________________________