NORTH PLATTE PHYSICAL THERAPY

EAST

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PEDIATRICS

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PHYSICAL / OCCUPATIONAL THERAPY REFERRAL

Patient's Name _____ Date of Birth _____

Address _____

Diagnosis _____

_____

Referring Physician _____ Code _____

Onset/Surgery Date _____ Patient Aware of Dx _____ yes _____ no

_____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
- _____Dry Needling
- _____Other

_____Hand Program

_____Splint/Orthotic Fabrication

_____Functional Capacity Evaluation

_____Work Site Evaluation

_____Work Hardening/Conditioning

Special Instructions _____

_____

Frequency _____ Duration _____

Goals _____

Precautions _____

Date _____ Signature **X** _____