

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 _____ yes _____ no

TREATMENT DESIRED

- | | | |
|--|---|---|
| <input type="checkbox"/> Evaluate and Treat
<input type="checkbox"/> Modalities
<input type="checkbox"/> Hot/Cold Pack
<input type="checkbox"/> Ultrasound/Phonophoresis
<input type="checkbox"/> Electrical Stimulation
<input type="checkbox"/> TENS
<input type="checkbox"/> Iontophoresis
<input type="checkbox"/> Parafin
<input type="checkbox"/> Traction | <input type="checkbox"/> Therapeutic Exercise
<input type="checkbox"/> AROM
<input type="checkbox"/> PROM
<input type="checkbox"/> Strengthening
<input type="checkbox"/> Stretching
<input type="checkbox"/> Pool
<input type="checkbox"/> Gait Training
<input type="checkbox"/> Lifting/Posture Instruction
<input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Manual Therapy
<input type="checkbox"/> Soft Tissue
<input type="checkbox"/> Joint Mobilization
<input type="checkbox"/> Other
<input type="checkbox"/> Hand Program
<input type="checkbox"/> Splint/Orthotic Fabrication
<input type="checkbox"/> Functional Capacity Evaluation
<input type="checkbox"/> Work Site Evaluation
<input type="checkbox"/> Work Hardening/Conditioning |
|--|---|---|

Special Instructions _____

Discharge Date _____

Frequency _____ Duration _____

Goals _____

Precautions _____

Date _____ Signature X _____