

# **NORTH PLATTE** **PHYSICAL THERAPY**

**EAST**

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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

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

Special Instructions \_\_\_\_\_

Frequency \_\_\_\_\_ Duration \_\_\_\_\_

Goals \_\_\_\_\_

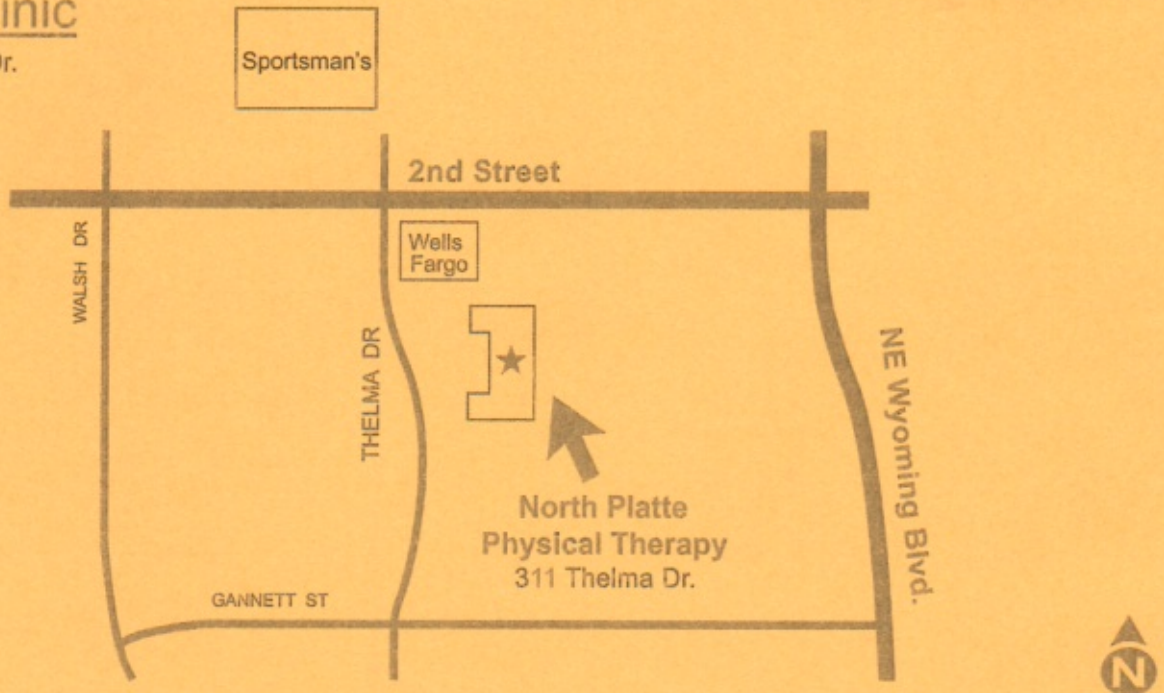
Precautions \_\_\_\_\_

Date \_\_\_\_\_ Signature X \_\_\_\_\_



★ East Clinic

311 Thelma Dr.



★ West Clinic

3831 Denis Dr.

