NORTH PLATTE PHYSICAL THERAPY

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PHYSICAL THERAPY REFERRAL

Patient's Name: _____ Date of Birth: _____

Address: _____

Diagnosis: _____

Referring Physician: _____ ICD 10 Codes: _____

Onset Date: _____ Patient aware of Dx?: (Yes) No

TREATMENT DESIRED

Evaluate and Treat

Modalities	Therapeutic Exercise	Manual Therapy	Other
Hot/cold pack	AROM	Soft Tissue	Splint/Orthotic Fabrication
Ultrasound	PROM	Cupping	Functional Capacity Evaluation
Iontophoresis	Stretching	Graston	Strapping/Kinesiotape
Phonophoresis	Strengthening	Joint Mobilization	Work Site Evaluation
Electrical Stimulation	Gait Training	ASTY/IAMT	Work Hardening/Conditioning
TENS	Lifting/Posture Instruction		Functional Dry Needling
Paraffin	Home Exercise Program		
Traction			

Special Instructions: _____

Pt. Discharge:_____ Discharge Date: _____

Reason for discharge: _____

Frequency:_____ Duration: _____

Goals: _____

Precautions: _____

Date: _____ Signature X: _____