# BIG COUNTRY REHABILITATION, LLC

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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 | _____Hot/Cold Pack | ____Manual Therapy |
| _____Cognitive Evaluation | _____Ultrasound/Phonophoresis | _____Soft Tissue |
| _____Pelvic Floor | _____Electrical Stimulation | _____Joint Mobilization |
| _____Vestibular/Concussion | _____IFC/Russian/HVGS | _____Graston/Cupping |
| _____Work Hardening | _____Therapeutic Exercise | _____Kinesio Tape |
| _____Adaptive Driving | _____AROM | _____Iontophoresis |
| _____Splint/Orthotic Fabrication | _____PROM/Stretching | _____Traction: Lumbar/Cervical |
| _____Functional Dry Needling | _____Strengthening | _____Wound Care |
| _____Aquatic Therapy | _____Gait Training | _____Dressing |
| _____Home Exercise Program | _____Functional Activities | _____Debridement |

Other

Frequency: 2-3X PER WEEK Duration: 30 DAYS

Goals: DECREASE PAIN, INCREASE ROM AND STRENGTH TO IMPROVE FUNCTION.

Precautions:

Effective Date: Signature: Date