



Physical Therapy Referral Form

Patient Name: _____

Diagnosis _____

Date of Injury _____ Next MD. Appt. _____

EVALUATE & TREAT

R_x Frequency: _____ days/week for _____ weeks.

Precautions: _____

POOL THERAPY

- POOL EXERCISES
- GAIT TRAINING
- RANGE OF MOTION
- STRENGTH TRAINING
- FLOATING TRACTION
- OTHER: _____

LAND THERAPY

- EXERCISES
- SOFT TISSUE MOBILIZATION
- JOINT MOBILIZATION
- RANGE OF MOTION
- STRENGTH TRAINING
- GAIT TRAINING
- MODALITIES
- OTHER: _____

I verify that physical therapy is medically necessary for this patient, that rehabilitation services will be rendered while the patient is under my care, and that the established treatment plan will be reviewed every thirty days as the patient's condition requires.

MD Signature: _____ Date: _____

MD Name (print): _____ Phone: _____

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