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REFERRAL ORDER FOR PHYSICAL THERAPY

Please attach patient information including current insurance cards and prior office notes/imaging results. Thank you!

Patient Name: ____ **Date of Birth**: ___________________________

Primary Phone: ____________________________________ **Alternate Phone**: ___________________________________

Primary Insurance: _____________________________ **Secondary Insurance**: __________________________________

Diagnosis/ICD-10: ____

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Precautions: ____

PHYSICAL THERAPY SERVICES REQUESTED			
❐ Evaluate and Treat	❐ Vestibular Rehabilitation Evaluate and Treat	❐ Concussion Evaluate and Treat	❐ Post-Op Evaluate and Treat (please include recommended protocol/ precautions)
RECOMMENDATIONS TO INCLUDE			
❐ Therapeutic Exercise and Activities (ROM, strengthening, trunk stabilization)	❐ Neuromuscular Reeducation (balance, proprioception, muscle reeducation, vestibular rehabilitation)	❐ Manual Techniques (myofascial release, soft tissue mobilization, joint mobilization)	❐ Modalities (ultrasound, electrical stimulation, mechanical decompression/traction)
❐ Gait Training (improve gait pattern, instruction in use of an assistive device)	❐ Canalith Repositioning and Education (BPPV)	❐ LSVT BIG® for Parkinson's Disease	❐ Neurocom Computerized Dynamic Posturography (Sensory Organization Testing, Motor Control Testing, Adaptation Testing) / Dynamic Visual Acuity Assessment with Invision System
❐ Other Recommendations:			
FREQUENCY AND DURATION REQUESTED			
❐ Therapist Discretion		❐ _________ visits/week for _________ weeks	

Provider Signature: ____ **Date**: ___________________________