

Patient: _____ Phone: _____ DOB: _____

Doctor: _____ Dr. Phone: _____ ICD: _____

Diagnosis: _____ Precautions: _____

Physical Therapy Referral

Duration: _____ /week x _____ weeks

Home Program

△ Evaluate and customize a program based on individual's needs

Orthopedic/Sports

- △ E-Stim: IFES, TENs, Pre-Mod, NMES
- △ Gait Training/Balance
- △ Joint Mobilization
- △ Proprioception
- △ Range of Motion (PROM, AROM, AAROM)
- △ Sport Specific Training
- △ Therapeutic Exercise (Strength/PRE)
- △ Total Joint Program (Pre/Post)
- △ Traction (Lumbar, Cervical)

Functional Rehabilitation

- △ Activities of Daily Living (ADLs)
- △ Adaptive Equipment
- △ Gait Training/Balance
- △ LE Coordination/Strengthening
- △ Neuromuscular Re-Education
- △ Orthotic/Prosthetic Training
- △ Physical Therapy
- △ Transfer Training
- △ UE Coordination/Strengthening

Aquatic Therapy

- △ Gait Training/Balance
- △ Therapeutic Exercise

Other Programs

- △ Pilates
- △ Prenatal/Post Natal

Comments: _____

Signature: _____ Date: _____