Physical Therapy Referral

Patient: _____

Diagnosis: _____ Surgery Date: _____

Evaluate and Treat as Indicated ☐_____ Weight Bearing Status: _____

Frequency: (Circle) Daily 2x/Week 3x/Week Other: _____ Duration: _____

Hydrotherapy	Therapeutic Exercises	Manual Therapies	Home Units
☐Hot Packs	☐Passive Range	☐Joint Mobilization	☐Cervical Traction
☐Cold Packs/Cryotherapy	☐Active	☐Soft Tissue Mobilization	☐Lumbar Traction
☐Paraffin Bath	☐Isometric		☐NMES/TENS
	☐Progressive Resistive	☐Dry Needling	☐Other _____

Modalities	Therapeutic Activity	Goals
☐Electrical Stimulation	☐Gait Training	☐Decrease Pain
☐Iontophoresis	☐Balance Training	☐Decrease Edema
☐Traction	☐Run/Jump Program	☐Increase ROM
_____ lbs.	☐Thrower's Program	☐Increase Strength
_____ Lumbar	☐LSVT BIG	☐Increase Function
_____ Cervical	☐Vestibular	☐Increase Posture

Special Instructions/Precautions: _____

Physician Printed Name: _____ Date: _____

I certify that the above services are required and authorized by me:

_____ _____

Physician Signature Date

2030 Lay Dam Road, Clanton, AL 35045 | P: (205)755-6110 | F: (205)755-6108
Located inside St. Vincent's Chilton Hospital