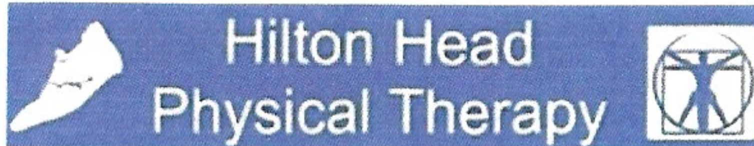


## OUTPATIENT PHYSICAL THERAPY REFERRAL

Patient Name:______________________________________________
Phone:______________________________ DOB____________________
ICD 10 Code:________________ Diagnosis:______________________________

Special Instructions______________________________________________
__________________________________________________________________
__________________________________________________________________

**Frequency**: (1) (2) (3) (4) (5) **Duration**: (1) (2) (3) (4) (5) (6) (7) (8) (9)

___ **Evaluate and Contact MD** ___ **Evaluate and Treat**

**Modalities**: __ Electrical Stimulation ___ Moist Heat ___ Laser Tx ___ Ultrasound ___Cryotherapy
___ Paraffin Modalities of Choice ___ Dry Needling ___ Tens Home Use ___ Mechanical Traction

**Manual Therapy:**

Massage Traction Scar Mobilization Mobilization IASTM

**Progressive Weight Bearing:**

NWB R L UE LE
PWB R L UE LE
FWB R L UE LE

**ROM:** ___ PROM ___ AAROM ___ AROM

**Strengthening**: __ Isometric __ Isotonic __Isokinetic
___ PRES ___ Open Chain ___Closed Chain

**Specific Strengthening**: ______________________________
__________________________________________________

**Core Stabilization**: ______________________________

___ Neutral Spine ______________________________

___ Physioball ______________________________

___ Flexion Bias Exercises

___ Extension Bias Exercises

Physician Signature: ______________________________ Date: __________

Physician Phone Number: ______________________________

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