



## Physical Therapy Referral

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Dx: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_

Duration of Treatment:  1  2  3 times a week for \_\_\_\_\_ weeks

**Evaluation & Treatment**

- Peripheral Joint Program
- Back Care Program
- Neck Care Program
  
- Gait assessment + training
  
- Protocol-specific request  
(please attach to referral)
  
- Orthotics
  
- Home Therapy

**Therapeutic Activities**

- ROM
- Strength Training
- Flexibility Training
- Balance Training
- Proprioceptive Training
- Endurance Training
- Dynamic Stabilization
- Sport-Specific Training Program
- Home Exercise Program
  
- Joint Mobilization
- Soft/Deep Tissue Mobilization
- Proprioceptive Neuromuscular Facilitation

**Modalities**

- Ice
- Heat
- Vasopneumatic+Cryo  
Compression [GameReady]
- Ultrasound
- Biofeedback
- TENS
- Interferential Current
- Electrical Stimulation
- Iontophoresis
- Traction

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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