snovalley
PHYSICAL THERAPY

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Provider Referral Form - Physical Therapy

Patient Name:_____ DOB:_____

ICD-10:_____ Patient Phone:_____

Diagnosis:_____

Notes:_____

_____

Treatment Methods

- ❑ Functional and Corrective Exercise Training
- ❑ Postural Restoration
- ❑ Soft Tissue Mobilization
- ❑ Myofascial Release
- ❑ Foot Orthotics
- ❑ Therapeutic Massage
- ❑ Neuromuscular Relaxation Training
- ❑ Bracing / Taping
- ❑ Home Exercise Program
- ❑ Joint Mobilization
- ❑ Sport-Specific Rehab
- ❑ ROM (Circle One) Passive / Active
- ❑ Cranio-Sacral Therapy
- ❑ Somato-Emotional Release
- ❑ Breath Therapy

Modalities

- ❑ Heat
- ❑ Ultrasound
- ❑ Ice
- ❑ Electrical Stimulation
- ❑ Parafin Bath

Treatment Frequency:_____ times for_____weeks

Physician Signature:_____ Date:_____

Physician Name (Print):_____ Recheck Date:_____