Physical Therapy Referral
(Central / South Orange Country Area)

Name: ____

Diagnosis/ICD9.Code: ________________________________

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☐ Physical Therapy Evaluation and Treatment as indicate

Procedures

- ☐ Therapeutic Exercises
- ☐ Therapeutic Activities
- ☐ Gait Training
- ☐ Neuromuscular Re-Education
- ☐ Spinal Stabilitazion Program
- ☐ McKenzie Protocol
- ☐ Manual Therapy
  - ( ) Joint Mobilization
  - ( ) Soft Tissue Mobilization
  - ( ) Strain-Counterstrain
  - ( ) Manual Traction
  - ( ) Other

Modalities

- ☐ As Needed for Pain, ROM, and Inflammation
- ☐ Hot / Cold Packs
- ☐ Ultrasound
- ☐ Iontophoresis with 4 mg / ml Dexamethasone
- ☐ Other________________

Goals of Treatment

- ☐ Pain
- ☐ Swelling
- ☐ Range motion
- ☐ Strength
- ☐ Improve function

All patients are provide with an individualized education and home program.

Special Intructions / Precautions ________________________________

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Frequency / Duration________________ Times for__________ (weeks)

I certify the need for these service furnished under this treatment plan while under my care.

Physician Signature________________ Date ______

Print Name______________________________

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