Pillars Physical Therapy
and Wellness Center

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PHYSICAL THERAPY REFERRAL

TO: _____ FAX NO: _____

Patient Name: _____ Phone No: _____

Diagnosis: _____

Diagnosis Code: _____

Physician: _____

Treatment Requested

☐Evaluate and treat, progress as needed

☐Exercise and modalities as appropriate

Modalities and Procedures:

- ☐ **Heat**
- ☐ **Ice**
- ☐ **Electrical Stimulation / TENS**
- ☐ **Ultrasound**
- ☐ **Paraffin**
- ☐ **Traction**
- ☐ **Therapeutic Exercise**
  - ☐PROM
  - ☐AAROM / AROM
  - ☐Stretching / Flexibility
  - ☐Strengthening
  - ☐Stabilization
  - ☐Conditioning
- ☐ **Manual Therapy**
  - ☐Soft tissue Mobilization
  - ☐Joint Mobilization
  - ☐Myofascial Release
- ☐ **Gait Training**
  - ☐Weight Bearing Status _____
- ☐ **Neuromuscular Re-education**
  - ☐Balance / Coordination
  - ☐Posture / Proprioception
- ☐ **ADL / Functional Training**
- ☐ **Patient Education / Home Exercise Program**
- ☐ **Orthopedic / Prosthetic Fitting and Training**
- ☐ **Others** _____

Frequency and Duration

_____ times a week for _____ weeks.

Special Instructions / Precautions: _____

_____

_____

_____

Note: Frequency and duration may be affected by individual's insurance coverage.

Date of Next Physician Visit: _____ Physician's Phone No.: _____

_____ _____

Physician's Signature Date

(I hereby certify that this treatment is medically necessary)