perception

PHYSICAL THERAPY

Physical Therapy Referral

Patient Name:_____DOB:_____

Physician:_____

Diagnosis:_____

Precautions/Comments:_____

- ❑ Evaluate and Treat
- ❑ Therapeutic Exercise
- ❑ Neuromuscular Re-Education
- ❑ Gait Training
- ❑ Manual Therapy
- ❑ Therapeutic Activities
- ❑ Post-Operative Rehab
- ❑ Pre-Surgical Conditioning (Prehab)
- ❑ LSVT Big® Program (Parkinson's)
- ❑ Postural Restoration® Evaluate and Treat

❑ Other:_____

Goals: ❑ Improve ROM ❑ Improve Strength ❑ Improve Mobility
❑ Improve Function Other:_____

I hereby certify that Physical Therapy is medically necessary for this patient's plan of care

Number of visits per week: 1 2 3 4 5
Treatment duration:_____ weeks

_____ _____
Signature Date

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