

Physical Therapy Referral Form

□ 80 Songbird Forest Rd. □ 90 East Main Street □ 594 Centennial Dr.

Bryson City, NC 28713 Sylva, NC 28779 Cullowhee, NC 28723

Phone: 828-488-0040 Phone: 828-550-3923 Phone: 828-293-4662

Fax: 828-354-0209 Fax: 828-354-0209 Fax: 828-354-0209

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis/Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Precautions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Evaluate and Treat

□ Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| * Therapeutic Exercise * Neuromuscular Re-ed * Manual Therapy * Posture Correction * Body Mechanics * Home Exercise Program * Orthotics Consult * Balance/Fall Prevention * Vestibular Rehab * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Modalities:   * Therapist Discretion * Hot Pack * Cold Pack * Ultrasound * E-Stim * TENS Unit * Iontophoresis * Phonophoresis |
|  |  |

Frequency/Duration: \_\_\_\_\_\_\_ Times per Week for \_\_\_\_\_\_\_\_Weeks. Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Therapist Discretion

Physician/Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Follow up Date: \_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I hereby certify that physical therapy is medically necessary for this patient’s plan of care.*