REFERRAL FORM

PATIENT NAME:_____ DATE:_____

DATE OF BIRTH:_____ PHONE NUMBER: ( )_____

DIAGNOSIS:_____

FREQUENCY/DURATION: ☐ 1X ☐ 2X ☐ 3X /WEEK X _____ WEEKS ☐ THERAPIST DISCRETION

REQUESTED SERVICES:

- ☐ THERAPEUTIC EXERCISES
- ☐ STRENGTHENING
- ☐ INCREASE RANGE OF MOTION
- ☐ MOBILIZATION
- ☐ MANUAL THERAPY
- ☐ E-STIM/ULTRASOUND
- ☐ IONTOPHORESIS
- ☐ GAIT TRAINING
- ☐ LUMBAR/CERVICAL TRACTION
- ☐ HOME EXERCISE PROGRAM

SPECIALTIES:

- ☐ ORTHOTICS
- ☐ BLOOD FLOW RESTRICTION THERAPY
- ☐ TPI GOLF PERFORMANCE PROGRAM
- ☐ OTHER:_____

REFERRED TO:

- ☐ THERAPIST:_____
- ☐ SOONEST AVAILABLE ☐ URGENT

DATE OF SURGERY:_____

COMMENTS/PRECAUTIONS:_____

REFERRING PROVIDER PRINTED NAME:_____

REFERRING PROVIDER SIGNATURE:_____ DATE:_____

PLEASE FAX THIS FORM TO (360)714-0872

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