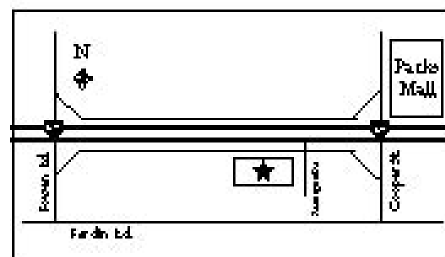

Patient Name: ____________________ H Phone: ____________ Other Phone: ____________

Diagnosis: ______________________________ ICD.10 Code: ________________________

Frequency: __________________ x's per week. Duration: __________________________

☐ **Therapy Evaluation and Treatment Services/Procedures**

☐ **Continue Therapy Treatment Programs**

Please attatch patient demographic and office notes to referral.

- ☐ Therapudic Exercise
  - ☐ Passive
  - ☐ Active
  - ☐ Stabilization
  - ☐ Strenghening
  - ☐ Functional Activities
- ☐ Neuromuscular Re-education
- ☐ Modalities as needed
- ☐ Iontophoresis
- ☐ Manual Therapy
- ☐ Massage
- ☐ Gait Training
- ☐ Hand Therapy
- ☐ Custom Sprint/ Orthotics
- ☐ Other: ___________________________

- ☐ Specific Protocol
- ☐ Home Exercise Program
- ☐ Work/Functional Conditioning
- ☐ Back/Neck School
- ☐ Body Mechanics Training
- ☐ Sport Injury Prevention
- ☐ Fitness Program
- ☐ Lymphedema
- ☐ Fibromyalgia
- ☐ Dry Needling

Evaluations:

- ☐ IFC/ TENS/ NMES Evaluation
- ☐ Lumbar/Cervical Traction
- ☐ Other: ________________________________
- ☐ Self Pay Program

Physician certifies that the prescribed therapy is of medical necessity.

Special Instructions: ____

Referring Physician: ________________________________ Date: ____________________

City/State: ___________________________ Phone: ____________________ Fax: __________

Signature: ______________________________________ NPI#: ________________________