APT

ARLINGTON PHYSICAL THERAPY

2310 W I-20 Ste 204 Arlington, TX 76017
P: 817-466-7276 **F:** 844-283-4950
www.arlingtontxpt.com

Patient Name: _____ Phone: _____ DOB: _____

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
- ☐ SportInjury 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#: _____