



PHYSICAL THERAPY REFERRAL

Patient Name _____

DOB _____

Date of Onset _____

Diagnosis/Problem To Be Addressed _____

Precautions/Contraindications _____

TREATMENT RECOMMENDATIONS

PHYSICAL THERAPY

- Evaluation and Treatment
- Therapeutic and Home Exercise Instruction
- Gait Training
- Ultrasound
- Electrical Stimulation/TENS/NMES
- Manual Therapy
- Neuromuscular Re-education
- Functional Activity
- Iontophoresis/Dexamethasone/Lidocaine
- Traction: Cervical/Lumbar

Goals

- Increase ROM
- Increase Strength
- Increase Functional Activity
- Increase Balance
- Increase Soft Tissue Mobility
- Increase Joint Mobility
- Other

Frequency: _____ x/ Week For _____ Weeks

Other Orders _____

Physician Signature _____

Physician Name (Printed) _____

Date _____

Physician Phone, Fax (P) _____ (F) _____

Insurance Carrier _____

-Policy _____

-Authorization Number _____

Center For Pain Management
8805 N. Meridian St.
Indianapolis, IN 46260
Phone: (317) 706-PAIN Fax: (317) 706-3417