



Physical Therapy Referral

Patient Name _____ Date of Birth _____

Diagnosis _____

Precautions _____

Evaluate and Treat

Continue PT

- Pre/Post Procedure/Surgery Protocol _____
- Functional Capacity Evaluation (FCE)
- Functional Restoration Program (FRP)
- Pre-placement Screening
- Job-site Analysis
- Headache Program
- Stabilization Program
- Pelvic Pain
- Other: _____
- Supply patient with Durable Medical Equipment:
 - Lumbar Brace __ SIJ Brace __ Wrist Brace __ Home E-Stim Unit __

Frequency of visits: 1-2x/week 2-3x/weeks 3-5x/week Other _____

Duration of visits: 2 weeks 3 weeks 4 weeks Other _____

Report by: Phone Letter None required

Referring Physician (print) _____ Date _____

Referring Physician (signature) _____

Phone Number _____ Fax Number _____

(For PT office only) PT start Date _____

ICD-9 Codes _____