MultiCare

Physical Therapy Referral Form

Patient's Name:_____Date:_____

DOB:_____

Patient's Contact Number:_____

Physician's Name:_____

Diagnosis:_____

Medical Precautions:_____

TREATMENT / MODALITIES:

- ❑ Physical Therapy Evaluation & Treatment
- ❑ Spinal Decompression
- ❑ Post Surgical Therapy
- ❑ Sports Injury Assessment
- ❑ Therapeutic Exercises
- ❑ McKenzie Exercises
- ❑ Neuromuscular Re-Ed
- ❑ Posture / Body Mechanic Education
- ❑ Manual Joint Mobilization
- ❑ Trigger Point Therapy
- ❑ Myofascial Release
- ❑ Electrical Stimulation (TENS)
- ❑ Ultrasound
- ❑ Kinesotaping
- ❑ Gait Analysis / Training
- ❑ Class IV Laser Therapy
- ❑ Vestibular / Balance Therapy
- ❑ TMJ
- ❑ Fall Prevention Therapy
- ❑ Pre/Postnatal Back Therapy

Frequency: ❑Therapist Discretion ❑ 1x/Week ❑ 2x/Week ❑3x/Week ❑5x/Week

Duration: ❑Therapist Discretion ❑4 Week ❑6 Week ❑8 Week ❑10 Weeks

I hereby certify these services as medically necessary for the patient's plan of care.

Physician's Signature:_____Date:_____

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