Island Physio LLC
Physical Therapy

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Physical Therapy Referral Form

Patient's Name _____ Date of Birth _____

Patient's Contact Number _____ Date of Injury/Surgery _____

Diagnosis _____ ICD-10 Code _____

Precautions _____

- ☐ **Evaluate and Treat**
  - _____ x/week for _____ weeks
  - _____ Total number of treatments
- ☐ **Manual Therapy**
  - ☐ Joint Mobilization
  - ☐ Soft Tissue Massage
  - ☐ Myofascial Release
- ☐ **Therapeutic Exercises**
  - ☐ Strengthening
  - ☐ Stretching
  - ☐ Home Exercise Program
  - ☐ Postural Education/Ergonomics
- ☐ **Modalities**
  - ☐ Mechanical Traction
  - ☐ Electrical Stimulation
  - ☐ Ultrasound
- ☐ **Gait/Balance Training**
- ☐ **Vestibular Rehabilitation**
- ☐ **Other _____**

Physician's Name (print): _____ Phone: _____ Fax: _____

Physician's Signature: _____ Date: _____