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Patient Name: _____ Date of Birth: _____

Patient Phone # _____ Patient Email: _____

Referring Physician: _____ Date: _____

Diagnosis: _____

Special Instructions:

☐

Evaluate & Treat

☐

Continue Current Rx

Patient Education

- ☐ Home Exercise Program
- ☐ Fall Prevention
- ☐ ADL Training
- ☐ Other: _____

Programs

- ☐ Balance Retraining
- ☐ Vestibular Therapy
- ☐ Headaches
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ S/P CVA
- ☐ Parkinson's
- ☐ Sports Specific
- ☐ Work Specific
- ☐ Stretch Clinic
- ☐ Wellness Program
- ☐ Pelvic Health

Pre/ Post-Op Rehabilitation

- ☐ Knee
- ☐ Hip
- ☐ Back
- ☐ Shoulder
- ☐ Neck
- ☐ Elbow
- ☐ Wrist/Hand
- ☐ Ankle/Foot

Modalities

- ☐ Ultrasound
- ☐ Electrical Stimulation
- ☐ Iontophoresis
- ☐ Traction
- ☐ Ice Massage/Packs
- ☐ Moist Heat
- ☐ Dry Needling
- ☐ Other: _____

Balance Rehabilitation

- ☐ Balance Retraining Therapy
- ☐ Epley Maneuver (Manual)
- ☐ Neurological Gait Training

Orthopedic Rehabilitation

- ☐ Strengthening
- ☐ Flexibility/R.O.M.
- ☐ Stabilization
- ☐ Soft Tissue Mobilization
- ☐ Joint Mobilization
- ☐ Other: _____

Frequency: _____ Days per week

Duration: _____ Weeks / Months

Physician Signature: _____ Date: _____

Physician Office Number: _____

Physician Fax Number: _____