Physiotherapy Associates

Lenox/Buckhead Location
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REFERRAL FORM

PATIENT INFORMATION

Name: _____ Phone: _____ Date: _____

Diagnosis/Condition: _____ ICD9#: _____

Surgical Procedures: _____

INSTRUCTIONS:

- ☐ EVALUATE AND TREAT
- ☐ EVALUATION
- ☐ JOB SITE ANALYSIS
- ☐ GAIT ANALYSIS
- ☐ BIOFEEDBACK
- ☐ REPLACEMENT SCREENING
- ☐ CONTACT BEFORE COMMENCING WITH TREATMENT
- ☐ FUNCTIONAL CAPACITY

TREATMENT GOALS:

- ☐ INCREASE R.O.M.
- ☐ INCREASE STRENGTH
- ☐ IMPROVE FUNCTION
- ☐ INCREASE MOBILITY
- ☐ DECREASE PAIN
- ☐ DECREASE EDEMA
- ☐ INCREASE GENERAL FITNESS
- ☐ IMPROVE PATIENT & FAMILY EDUCATION

MODALITIES:

- ☐ HEAT
- ☐ COLD
- ☐ WHIRLPOOL
- ☐ ELECTRICAL STIMULATION
- ☐ VASOPNEUMATIC COMPRESSION
- ☐ FLUIDOTHERAPY
- ☐ IONTOPHORESIS
- ☐ PARAFFIN BATH
- ☐ ULTRASOUND

PROCEDURES:

- ☐ MASSAGE/SOFT TISSUE MOB.
- ☐ MOBILIZATION
- ☐ TRACTION
- ☐ WORK CONDITIONING
- ☐ JOB COACHING
- ☐ McKENZIE/WILLIAM'S EXERCISE
- ☐ THERAPEUTIC/ISOKENETIC EXERCISE
- ☐ TENS (HOME USE)
- ☐ TRANSITIONAL WORK PROGRAM
- ☐ ORTHOTICS/SPLINTS
- ☐ STABILIZATION
- ☐ PREVENTIVE BACK/NECK CLASSES
- ☐ FITNESS CONDITIONING PROGRAM

TREATMENT PLAN:

- ☐ THERAPIST'S DISCRETION
- ☐ DURATION OF TREATMENT UP TO _____ TIMES PER WEEK X _____ WEEKS
- ☐ FREQUENCY OF TREATMENT 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ (DAYS PER WEEK)

ADDITIONAL COMMENTS: _____

I hereby certify that the services indicated above are medically necessary.

PHYSICIAN SIGNATURE: _____ **DATE:** _____ **PHONE:** _____