A Physical Therapy Corporation

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PATIENT REFERRAL

PATIENT'S NAME: _____ **PHONE**: _____

DIAGNOSIS: _____

PRECAUTIONS: _____

FREQUENCY: □ DAILY □ 2-3 X WEEK □ 1 X WEEK

DURATION: 1 2 3 4 5 6 7 8 WEEKS

PHYSICAL THERAPY

□ **EVALUATION AND TREATMENT**

□ MANUAL THERAPY
□ MODALITIES
□ THERAPEUTIC EXERCISE
□ TRACTION
□ FUNCTIONAL ACTIVITIES
□ NEUROMUSCULAR RE-EDUCATION

COMMENTS: _____

_____

_____

PHYSICIAN SIGNATURE: _____ **DATE**: _____

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