FYZICAL® Therapy & Balance Centers

REHABILITATION REFERRAL

Major Insurance Plans Accepted

Patient's Name: _____ Patient's Phone: _____

Diagnosis: _____ Patient's DOB: _____

Provider Name (Print): _____ Frq/Dur: ____x____

☐ EVALUATE & TREAT at the Therapist's Discretion

Modalities
- ☐ Dry Needling
- ☐ Hot/Cold packs
- ☐ Ultrasound
- ☐ Paraffin Bath
- ☐ Cervical Traction
- ☐ Electrical Stimulation
- ☐ Iontophoresis

Specialty Programs
- ☐ Aquatic Therapy
- ☐ Balance Testing - BIODEX
- ☐ Pelvic Health Therapy
- ☐ Vestibular Rehabilitation
- ☐ Workwell FCE

Exercise Programs
- ☐ Stretching
- ☐ Strengthening
- ☐ Endurance/Conditioning
- ☐ Neuromuscular Re-Ed
- ☐ Balance/Proprioception
- ☐ Home Program
- ☐ Work Conditioning
- ☐ Ergonomics
- ☐ Fall Prevention

Testing
- ☐ ROM Evaluation
- ☐ Manual Muscle Training
- ☐ Fall Risk

Manual Therapy
- ☐ Myofascial Release/STM
- ☐ Massage
- ☐ Joint Mobilization
- ☐ Manual Traction
- ☐ ASTYM

Specialty Treatment
- ☐ ADL Training
- ☐ BTE
- ☐ Worker's Compensation
- ☐ Splinting
- ☐ Custom Orthotics
- ☐ Laser Therapy
- ☐ TMJ/TMJD

Splints
- ☐ Finger Based
- ☐ Hand Based
- ☐ Fore Arm Based

Notes & Precautions: _____

PT/OT Goals
- ☐ Increase ROM
- ☐ Increase Strength
- ☐ Increase Work Capacity
- ☐ Decrease Pain
- ☐ Decrease Swelling
- ☐ Eliminate Dizziness
- ☐ Improve Balance
- ☐ Improve Healing
- ☐ Improve Posture
- ☐ Improve Gait
- ☐ Improve ADL
- ☐ Improve Function

REFERRING PROVIDER INFORMATION

Provider Signature: _____ Date: _____

Certification: I certify that this treatment is medically necessary and required for the above named patient.