



Physical Therapy Referral

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Patient Name:	Date of Birth:
Address:	Phone:
Diagnosis:	ICD 9/10:

_____ Eval and Treat _____ X per week for _____ weeks

Physical Therapy:

- | | |
|--|-------------------------|
| _____ Myofascial Release | _____ Manual Therapy |
| _____ Vestibular Rehabilitation | _____ Balance Training |
| _____ Gait Training | _____ Strength Training |
| _____ Women's Health - may use internal/external techniques to address pelvic floor. | |

Physician Signature:	Date:
Physician Phone:	Fax: