

Physical Therapy Referral



Health and Healing
Physical Therapy

Patient Name: _____

Patient Date of Birth: _____

Diagnosis ICD10(Required) : _____

Patient Phone: _____

Physical Therapy Treatment Order

- | | |
|---|--|
| <input type="checkbox"/> Evaluate and Treat | <input type="checkbox"/> Manual Therapy |
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Biofeedback |
| <input type="checkbox"/> Per Therapist Discretion | <input type="checkbox"/> Home Exercise Program |

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Diagnosis:

- | | |
|---|--|
| <input type="checkbox"/> Pelvic Pain (R10.2) | <input type="checkbox"/> Vaginismus (N94.2) |
| <input type="checkbox"/> Lower Abdominal Pain (R10.3) | <input type="checkbox"/> Hip Pain (M25.559) |
| <input type="checkbox"/> Fecal Incontinence (R15.2) | <input type="checkbox"/> Low back Pain (M54.5) |
| <input type="checkbox"/> Fecal Urgency (R15.2) | <input type="checkbox"/> Thoracic Pain (M54.6) |
| <input type="checkbox"/> Dyspareunia (N94.1) | <input type="checkbox"/> Coccyx Pain (M53.3) |
| <input type="checkbox"/> Urinary Frequency (R35.0) | <input type="checkbox"/> Urge Incontinence (N39.41) |
| <input type="checkbox"/> Pubic Symphysis Pain (M25.559) | <input type="checkbox"/> Diastasis (M62.0) |
| <input type="checkbox"/> SI Joint Dysfunction (M53.3) | <input type="checkbox"/> Voiding Dysfunction (N39.9) |
| <input type="checkbox"/> Pelvic Floor Weakness (M62.5) | <input type="checkbox"/> Vulvodynia (N94.89) |

Other: _____

Referral signature

Date of Referral

Office Phone

Office Fax