Physical Therapy Referral

Health and Healing
Physical Therapy

821 SW Alsbury Blvd
Suite B
Burleson, TX 76028

Web: healthandhealingptcom

Email: amanda@healthandhealingpt.com

Phone: 682-231-1607

Fax: 682-803-0064

Patient Name:____

Patient Date of Birth:__________________________________

Diagnosis ICD10(Required) :_____________________________

Patient Phone:____

Physical Therapy Treatment Order

- ☐ Evaluate and Treat
- ☐ Therapeutic Exercise
- ☐ Per Therapist Discretion
- ☐ Manual Therapy
- ☐ Biofeedback
- ☐ Home Exercise Program

Diagnosis:

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

Other:_______________________________________

_________________________________ Name of Referring Provider

_________________________________ Office Name of Referring Provider

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Referral signature | Date of Referral | Office Phone | Office Fax