



Achieve
Relief

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Referral

Patient _____

Patient Phone Number _____ Date _____

Diagnosis/ICD-9 _____

Precautions/Remarks _____

Instructions: Evaluate & Treat

Report by: Phone Letter

Modalities: Heat
 Electrical Stim.
 Iontophoresis*

Cold
 Ultrasound
 Massage

Contrast
 Phonophoresis
 Friction Massage

Procedures: Mobilization
 Therapeutic Exercise
 __ Passive
 __ Isotonic
 __ Isometric

Gait Training
 __ Aerobic Conditioning
 __ Proprioception
 __ Functional Drills

ROM/Flexibility
 Traction
 __ Manual Traction
 __ Mechanical Traction
 __ Home Traction Unit

Other: Fall Prevention/Testing

Isokinetic*

Gait Analysis

**Not all services available at every clinic*

Treatment Plan: Therapists Discretion Daily

Frequency/Duration: 1 2 3 4 5 Times Per Week For _____ Weeks

Additional Comments _____

Physician's Signature _____

Thank You For This Referral