PHYSICIAN REFERRAL TO PHYSICAL THERAPY

Sports and Orthopaedic Therapy Services
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Silver Spring, Maryland 20904

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Patient Name:_____ Date:_____

Diagnoses: 1. _____ 2. _____

Frequency:_____/week Duration: _____weeks

Procedures/Modalities/Services Requested; Please circle all that apply:

Evaluate and Treat

Body Mechanics Training	Manual Therapy	Sports Specific Rehabilitation
Surgical Protocol	Joint mobilization	Ergonomic Education
Balance Training	Ultrasound	Chronic Pain Management
Electrical Stimulation	Traction	Neuromuscular Reeducation
Gait Training	Whirlpool	Postural Reeducation
Therapeutic Exercise	Home Exercise Program	Lumbar Stabilization
Massage	Kinesiotaping/McConnell Taping	TENS

Other Requested Services/Procedures/Modalities:_____

Clinical Precautions/Contraindications:_____

Pertinent diagnostic testing results:_____

Physician's Signature:_____ Date:_____/_____/_____

Map to our location: