PASADENA PHYSICAL THERAPY

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We accept:
PPO & POS Insurances
Worker's Compensation
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PHYSICAL THERAPY REFERRAL

NAME _____ DATE _____

DIAGNOSIS _____

PRECAUTIONS _____

☐ PHYSICAL THERAPY CONSULTATION TREATMENT:

Frequency x Duration: _____times per week for _____weeks

AREA:

☐ Cervical Spine
☐ Thoracic Spine / ribs
☐ Lumbar Spine
☐ Shoulder / rotator Cuff
☐ Elbow
☐ Wrist / Hand
☐ Hip
☐ Knee
☐ Ankle / Foot

TREATMENT: ☐ Per Examination Findings

☐ Joint Mobilization
☐ Soft Tissue Mobilization
☐ Myofascial Release
☐ Therapeutic Exercises & Stretches
☐ Patient Education / Home Program
☐ Modalities PRN
☐ Gait Training: __%
☐ Gait Training - WBAT
☐ Other_____

THERAPEUTIC EXERCISE / PROTOCOLS: ☐ As Appropriate

☐ Progressive Resistive with Periodization
☐ Rotator Cuff / Scapular Stabilization
☐ Accelerated ACL Protocol
☐ Spinal Stabilization Program
☐ Total Hip / Knee Arthroplasty
☐ Balance Training
☐ Neuromuscular Re-education
☐ Vestibular Rehabilitation

_____
Doctor's Signature

_____ _____
Please Print Doctor's Name Office Phone Number