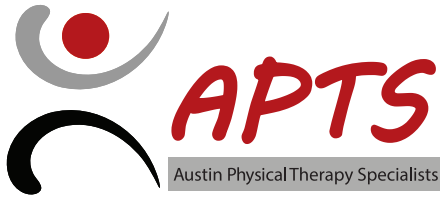


# Physical Therapy Referral Form



**Austin Physical Therapy Specialists**

www.Austin-PT.com

Phone: (512) 371-7273 • Fax: (512) 259-7056

7801 N Lamar Blvd. #B174, Austin, TX 78752

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Contact Number: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Medical Precautions: \_\_\_\_\_

## Physical Therapy Treatment / Modalities

- |  |   |
|--|---|
| <input type="checkbox"/> Physical Therapy Evaluation and Treatment | <input type="checkbox"/> Manual Joint Mobilization      |
| <input type="checkbox"/> Aquatic Therapy                           | <input type="checkbox"/> Trigger Point Therapy          |
| <input type="checkbox"/> Spinal Decompression                      | <input type="checkbox"/> Myofascial Release             |
| <input type="checkbox"/> Post Surgical Therapy                     | <input type="checkbox"/> Electrical Stimulation(TENS)   |
| <input type="checkbox"/> Sports injury Assessment                  | <input type="checkbox"/> Ultrasound                     |
| <input type="checkbox"/> Therapeutic Exercises                     | <input type="checkbox"/> Kinesotaping                   |
| <input type="checkbox"/> McKenzie Exercises                        | <input type="checkbox"/> Gait Analysis/Training         |
| <input type="checkbox"/> Neuromuscular Re-Ed                       | <input type="checkbox"/> Wheelchair/Mobility Assessment |
| <input type="checkbox"/> Posture/ Body Mechanic Education          | <input type="checkbox"/> Functional Training            |

## Specialty Services

- |  |   |
|--|---|
| <input type="checkbox"/> Dry Needling                | <input type="checkbox"/> Fall Prevention Therapy    |
| <input type="checkbox"/> Class IV Laser Therapy      | <input type="checkbox"/> TMJ                        |
| <input type="checkbox"/> Post Amputation Therapy     | <input type="checkbox"/> Pelvic Floor Therapy       |
| <input type="checkbox"/> Neuro/Post Stroke Therapy   | <input type="checkbox"/> Women's Health             |
| <input type="checkbox"/> Vestibular/ Balance Therapy | <input type="checkbox"/> Pre/Postnatal Back Therapy |

## Frequency & Duration

**Frequency:**     Therapist Discretion     1 x Week     2 x Week     3 x Week     5 x Week

**Duration:**     Therapist Discretion     4 Weeks     6 Weeks     8 Weeks     10 Weeks

I hereby certify these services as medically necessary for the patient's plan of care.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



Heated Pool



Class IV Laser



4,000 Sq Ft GYM



Dry Needling



Women's Health  
Pelvic Floor