



277 Indian Head Rd.  
Kings Park, NY 11754  
631-269-5170

## Physical Therapy Referral

Office Visit     Home Visit

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

- |  |  |
|--|--|
| <input type="checkbox"/> Moist Heat              | <input type="checkbox"/> Gait Training                                   |
| <input type="checkbox"/> Cryotherapy             | ___NWB ___PWB ___FWB   |
| <input type="checkbox"/> Electrical Muscle Stim. | <input type="checkbox"/> Exercise  |
| <input type="checkbox"/> Iontophoresis           | ___Active ___Passive   |
| <input type="checkbox"/> TENS/NTM                | ___Active Resistive  |
| <input type="checkbox"/> Ultrasound              | <input type="checkbox"/> Gen. Cond. Program                              |
| <input type="checkbox"/> Manual Traction         | <input type="checkbox"/> Low Back Program                                |
| <input type="checkbox"/> Mobilization            | <input type="checkbox"/> Williams Flex <input type="checkbox"/> McKenzie |
| <input type="checkbox"/> Massage                 | <input type="checkbox"/> Cerv. Program                                   |
| <input type="checkbox"/> Cyriax Friction Massage | <input type="checkbox"/> Postural Train./Body Mech.                      |
| <input type="checkbox"/> Myofascial Techniques   | <input type="checkbox"/> Evaluation & Treatment                          |

**Treatments:**  Daily or \_\_\_\_\_X/week for \_\_\_\_\_ weeks

**Special Instructions:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- Evaluate and Contact Physician
- Send progress notes to M.D. Evaluate and Test

\_\_\_\_\_  
Physician's Name (Please Print)

\_\_\_\_\_  
Referring Physician's Signature