ADVANTAGE PHYSICAL THERAPY

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Referring: Patient Name _____ for: **PT** **OT** **BOTH**

Diagnosis: _____

Special Instructions / Precautions: _____

- ❑ Evaluate and Treat
- ❑ Ultrasound / Phonophoresis
- ❑ Electrical Stimulation / Iontophoresis
- ❑ Traction (Manual / Mechanical)
- ❑ Low Level LASER Therapy
- ❑ Manual Therapy / Joint Mobilization
- ❑ Hot Pack / Cold Pack
- ❑ Therapeutic Exercise
- ❑ Neuromuscular Re-education
- ❑ Posture / Body Mechanics
- ❑ Balance Activities / Gait Training
- ❑ Back Stabilization / Pilates / Reformer
- ❑ Pelvic Rehabilitation
- ❑ Other: _____

Occupational Therapy

- ❑ Evaluate and Treat
- ❑ Home Safety Modification
- ❑ Education on adaptive techniques/equipment
- ❑ Stress Management
- ❑ Family / Caregiver Training

Treat: _____ times weekly for _____ weeks.

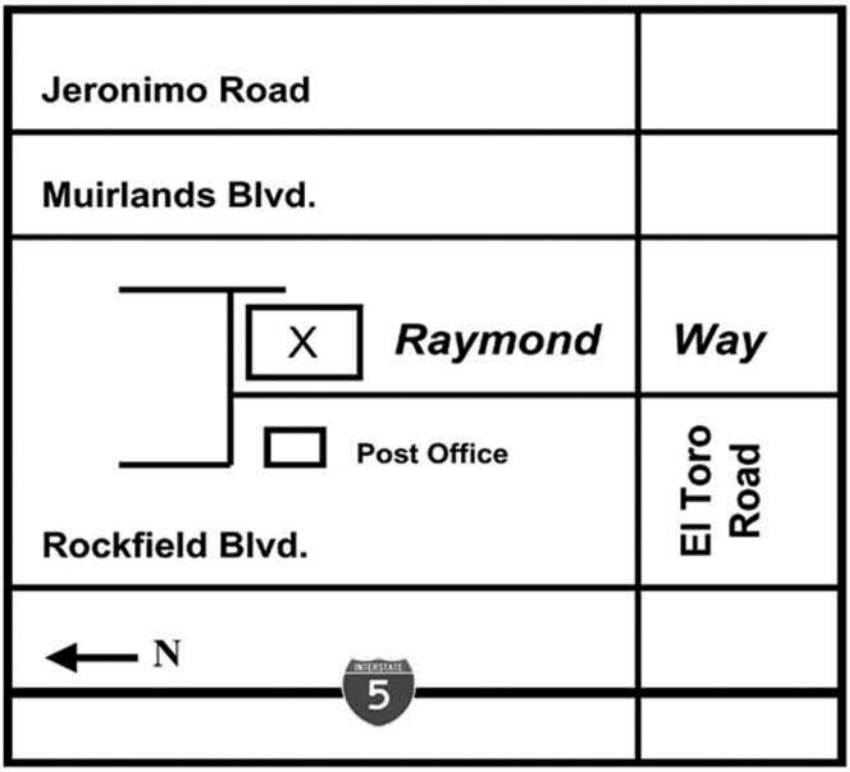
Prescribing Doctor: _____ NPI: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

Thank you for the Referral!



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FOR AN APPOINTMENT:
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