

ADVANTAGE PHYSICAL THERAPY

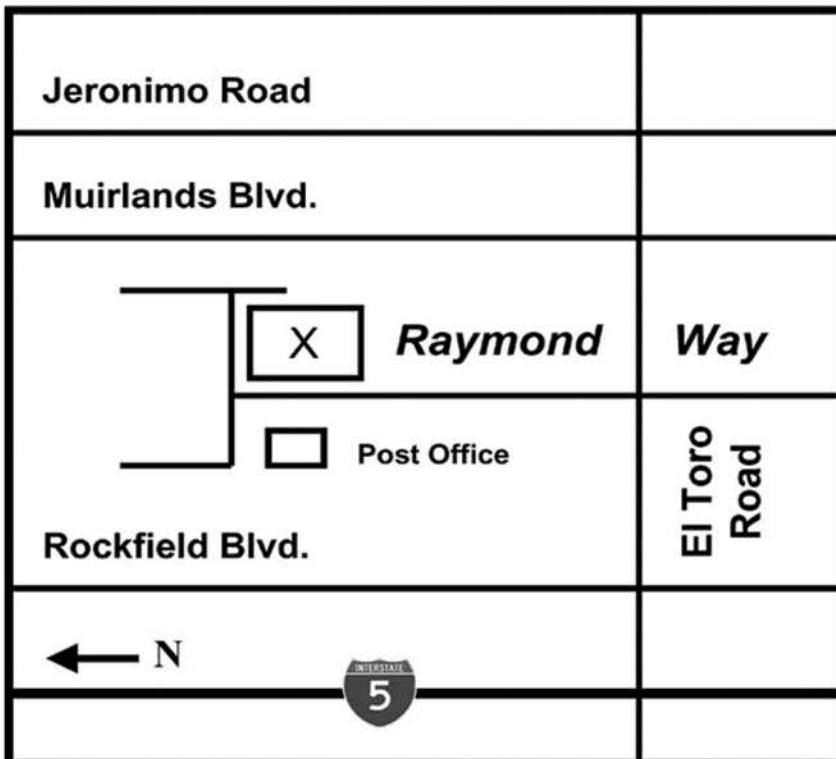
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Referring: Patient Name _____		for: PT OT BOTH
Diagnosis: _____		
Special Instructions / Precautions: _____		
<input type="checkbox"/> Evaluate and Treat <input type="checkbox"/> Ultrasound / Phonophoresis <input type="checkbox"/> Electrical Stimulation / Iontophoresis <input type="checkbox"/> Traction (Manual / Mechanical) <input type="checkbox"/> Low Level LASER Therapy <input type="checkbox"/> Manual Therapy / Joint Mobilization <input type="checkbox"/> Hot Pack / Cold Pack	<input type="checkbox"/> Therapeutic Exercise <input type="checkbox"/> Neuromuscular Re-education <input type="checkbox"/> Posture / Body Mechanics <input type="checkbox"/> Balance Activities / Gait Training <input type="checkbox"/> Back Stabilization / Pilates / Reformer <input type="checkbox"/> Pelvic Rehabilitation <input type="checkbox"/> Other: _____	Occupational Therapy <input type="checkbox"/> Evaluate and Treat <input type="checkbox"/> Home Safety Modification <input type="checkbox"/> Education on adaptive techniques/equipment <input type="checkbox"/> Stress Management <input type="checkbox"/> 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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LAKE FOREST, CA 92630

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**FOR AN APPOINTMENT:
(949) 305-8200**