PHYSICAL THERAPY REFERRAL

PREMIER PHYSICAL THERAPY
1020 S. Main Street • Milton-Freewater, Oregon 97862
(541) 938-2028 • Fax (541) 938-2029
Jared Hodgson, DPT
Connie Morgan, MSPT

Date_____ Dx Code _____

Name _____ Phone # _____

Diagnosis _____

Surgical Procedure _____

RX FREQUENCY _____ per week _____ weeks

☐ **EVALUATE AND TREAT**

☐ Manual Therapy
☐ Therapeutic Exercise
☐ Neuromuscular Re- education
☐ Gait/Balance Training
☐ Iontophoresis
☐ Ultrasound/Phonophoresis
☐ Aquatic Therapy
☐ Lumbar stabilization
☐ Pelvic Floor rehab
☐ Pregnancy/ Postpartum Rehab
☐ Soft Tissue Mobilization

☐ Moist Heat
☐ Cold Packs
☐ Paraffin
☐ Electrical Stimulation

Traction
☐ Cervical
☐ Lumbar

Industrial Rehabilitation

☐ Back School
☐ Physical Conditioning
☐ Physical Capacity Evaluation (PCE)
☐ Work Hardening

In signing this referral, physician certifies that rehab is medically necessary.
Precautions/ Instructions:

Physician Signature _____

Physician Name (Printed) _____