SPECTRUM MEDICAL

109 Bridge Street ◆ Suite 300
Danville, Virginia 24541
Phone (434) 793-4711 ◆ Fax (434) 792-2818

spectrummed.com

PHYSICAL THERAPY REFERRAL

Patient: _____ Date:_____

Diagnosis: _____ Date of Onset: _____

Precautions: _____

❑ **Evaluate and Treat as indicated** (check specific modalities and treatments if desire

PROCEDURES

- ❑ ROM (Active, Passive, Assistive)
- ❑ Strengthening
- ❑ Manual Techniques
- ❑ Functional Dry Needling (FDN)
- ❑ Core Rehab/Spinal Stabilization
- ❑ Athletic / Sports Specific Rehab
- ❑ Neurological Rehab
- ❑ Gait/Balance Training
- ❑ Vestibular Rehab
- ❑ Amputee Rehab
- ❑ Aquatic Therapy
- ❑ Home Exercise Program (HEP)
- ❑ Work Conditioning Program
- ❑ Rehab Program per Included Protocol

MODALITIES

- ❑ Heat/Ice
- ❑ Electrical Stimulation
- ❑ Compression
- ❑ Traction
- ❑ Ultrasound
- ❑ Whirlpool
- ❑ Wound Debridement (Sharp/Blunt)

TEST/MEASUREMENTS

- ❑ Functional Capacity Evaluation
- ❑ Impairment/Disability Rating
- ❑ Computerized Strength Testing

Special Instructions: _____

_____

Weight Bearing Status: _____

Frequency: _____x Per Week x _____Weeks Return Appt Date:_____

I certify the need for these services furnished under this plan of treatment and while under your care.

_____ _____

Physician Signature Date

_____

Physician Name (Print)