

SPECTRUM MEDICAL, INC
Rehabilitation & Physical Therapy

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PHYSICAL THERAPY REFERRAL

Patient: _____ Date: _____

Diagnosis: _____ Date of Onset: _____

Precautions: _____

Evaluate and Treat as indicated (check specific modalities and treatments if desired)

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