



929 Pacific Street, Monterey, CA 93940  
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## PHYSICAL THERAPY REFERRAL

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Telephone Number: \_\_\_\_\_ Onset: \_\_\_\_\_

# of Visits: \_\_\_\_\_ Over How Many Weeks? \_\_\_\_\_

Diagnosis: \_\_\_\_\_

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> EVALUATE & TREAT         | <input type="checkbox"/> Cold Laser              | <input type="checkbox"/> Whirlpool               |
| <input type="checkbox"/> Therapeutic Exercises    | <input type="checkbox"/> Vibration Platform      | <input type="checkbox"/> Electrical Stimulation  |
| <input type="checkbox"/> Home Exercise Program    | <input type="checkbox"/> Manual Techniques       | <input type="checkbox"/> Traction                |
| <input type="checkbox"/> Kinetics                 | <input type="checkbox"/> Postural / Biomechanics | <input type="checkbox"/> Ultrasound              |
| <input type="checkbox"/> Neuromuscular Retraining | <input type="checkbox"/> Proprioceptive Training | <input type="checkbox"/> Gait / Balance Training |

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Doctor's Signature: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Date: \_\_\_\_\_