PACIFIC PHYSICAL THERAPY

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PHYSICAL THERAPY REFERRAL

Patient Name: _____ DOB: _____

Patient's Telephone Number: _____ Onset: _____

# of Visits: _____ Over How Many Weeks? _____

Diagnosis: _____

- ☐ EVALUATE & TREAT
- ☐ Therapeutic Exercises
- ☐ Home Exercise Program
- ☐ Kinetics
- ☐ Neuromuscular Retraining
- ☐ Gait / Balance Training
- ☐ Vestibular
- ☐ Vibration Platform
- ☐ Manual Techniques
- ☐ Postural / Biomechanics
- ☐ Proprioceptive Training
- ☐ Pilates
- ☐ Whirlpool
- ☐ Cold Laser
- ☐ Electrical Stimulation
- ☐ Traction
- ☐ Ultrasound

Comments: _____

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_____

Doctor's Signature: _____

Doctor's Name: _____ Date: _____