TEXAS PHYSICAL THERAPY SPECIALISTS

The Best First Choice®

PHYSICAL THERAPY REFERRAL & CONSULTATION

Patient Name: _____ Date: _____

Patient Phone: _____ Patient DOB: _____

Diagnosis: _____

Request: ○ **Evaluate and Treat** ○ Evaluation Only ○ EMG/NCV Testing ○ Pre Rehab

Frequency: _____ Duration: _____

If you request selective intervention for this patient, indicate below:

- ○ Range of Motion
- ○ Electrical Stimulation
- ○ Soft Goods (inserts/braces)
- ○ ISTM
- ○ Gait Evaluation/Training
- ○ Heat/Cold/TENS
- ○ Therapeutic Exercise
- ○ Manual Therapy
- ○ Ionto/Phonophoresis
- ○ Plyometrics
- ○ Traction
- ○ Vestibular/Balance

Specialty:

- ○ De-weighting Treadmill Training
- ○ Running/Sports Examination & Assessment
- ○ Alter G Treadmill Therapy
- ○ Aquatic Therapy (SwimEx600T)
- ○ Wellness/Cardio Evaluation & Exercise Prescription

Comments: _____

_____

_____

I certify that the treatment is medically necessary and will be reviewed every 30 days.

_____ _____

Referring Provider's Signature *Please Print Name*

Best Practice Award Winner from the Private Practice Section of the American Physical Therapy Association

www.TexPTS.com

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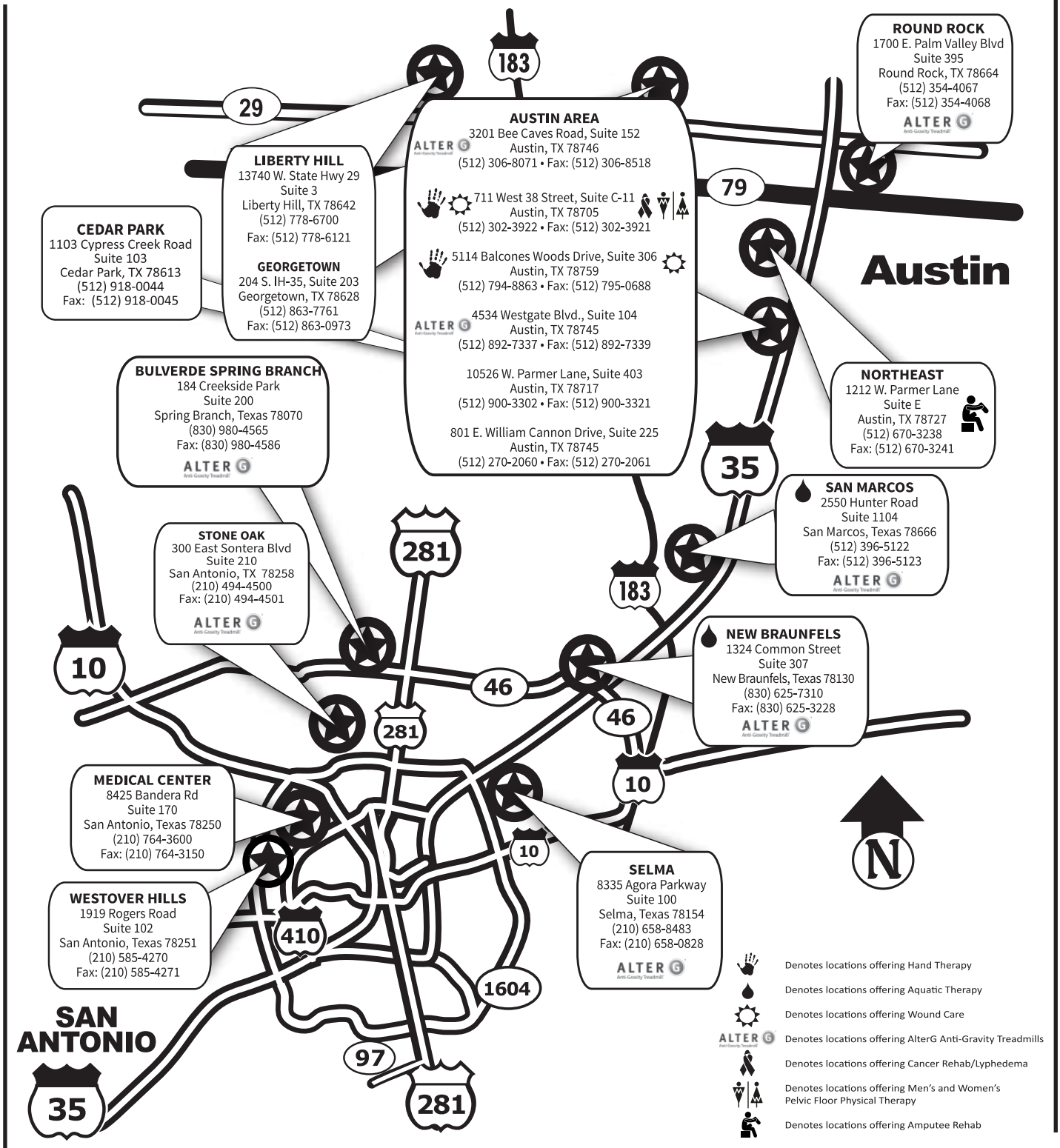

Revised 7/15

Additional locations in Dallas