ProTailored Physical Therapy LLC

4 Convenient Locations In Fort Wayne!

Phone: (260) 739-0300 • Fax: (260) 818-2299

www.protailored.com

Physical Therapy Referral

Patient's Name: _____ DOB: _____

Patient's Contact Number: _____

Physician's Name: _____

Diagnosis: _____

Orthopedic Physical Therapy Diagnosis

- ❑ Low Back Pain
- ❑ Neck Pain
- ❑ Shoulder Pain
- ❑ Elbow/Hand Pain
- ❑ Hip Pain
- ❑ Knee Pain
- ❑ Foot Pain
- ❑ Headache/Migraine
- ❑ Other_____

Pelvic Health Physical Therapy Diagnosis

- ❑ Urinary Incontinence (stress, urge, mixed)
- ❑ Pelvic Floor Muscle Weakness
- ❑ Pelvic Organ Prolapse
- ❑ Pelvic Pain
- ❑ Dyspareunia
- ❑ Pelvic Floor Muscle Spasm
- ❑ SI J Pain/Public Symphysis Dysfunction
- ❑ Other_____

Physical Therapy Treatment/Modalities:

- ❑ Physical Therapy Eval. & Treat
- ❑ Electrical Stimulation
- ❑ Class IV Laser Therapy
- ❑ Biofeedback
- ❑ Soft Tissue Mobilization
- ❑ Neuromuscular Re-education
- ❑ Functional Training
- ❑ Pelvic Floor Exercises
- ❑ Core Stabilization Exercises
- ❑ Traction
- ❑ Strengthening Exercises
- ❑ Joint Mobilization/Manipulation
- ❑ Dry Needling
- ❑ Other_____

Treatment Frequency:

❑ Therapist Discretion ❑ _____

Special Instructions/Comments: _____

I hereby certify these services are medically necessary for the patient's plan of care

Physician's Signature_____ Date_____