Bench Mark
PHYSICAL THERAPY
Patient Satisfaction is Our Highest Priority

PHYSICAL THERAPY REFERRAL

Patient's Name: _____ DOB: _____

Phone:_____ SS#: _____ DOI: _____

Diagnosis: _____

Comments: _____

ORDERS:

☐ Evaluate and Treat
☐ Re-Evaluate and Continue Treatment
☐ Functional Capacity Evaluation (FCE)
☐ Work Conditioning

FREQUENCY: _____ x Week **DURATION:** _____ Weeks

MODALITIES/PROCEDURES:

☐ Therapeutic Massage
☐ Electrical Stimulation
☐ Functional Electrical Stim.
☐ Passive ROM
☐ Passive Stretching
☐ Joint Mobilization
☐ Active-Assisted ROM
☐ Vestibular Rehab
☐ Hand Therapy
☐ Gait Training
☐ Dynamic Balance Training
☐ Iontophoresis
☐ Myofascial Release
☐ TMJ Program
☐ Progressive-Resistance Ex.
☐ Light Therapy
☐ Therapeutic Ultrasound
☐ Other: _____

INSURANCE:

☐ Medicare ☐ Medicaid ☐ Private Insurance ☐ Worker's Comp ☐ Private Pay ☐ Veterans Affairs (VA)

Policy/Claim Information: _____

PHYSICIAN'S SIGNATURE: _____ Date: _____

Physician's Printed Name: _____ Phone:_____ Fax: _____

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