Physical Therapy Referral

Patient Name *(Please print)*: ____

Patient Date of Birth: ____________________ Today's Date: ____________________

Home Phone: ________ / ________ / ________ Cell Phone: ________ / ________ / ________

Diagnosis: ____

____

Frequency: ____ visit/week

Duration: ____ weeks

Precautions/Special Considerations: ____

____

☐ **EVALUATE AND TREAT**

☐ Therapeutic Exercise ☐ Manual Therapy ☐ Dry Needling

☐ Modalities as Needed ☐ Bracing or Taping

Other (specify): ____

____

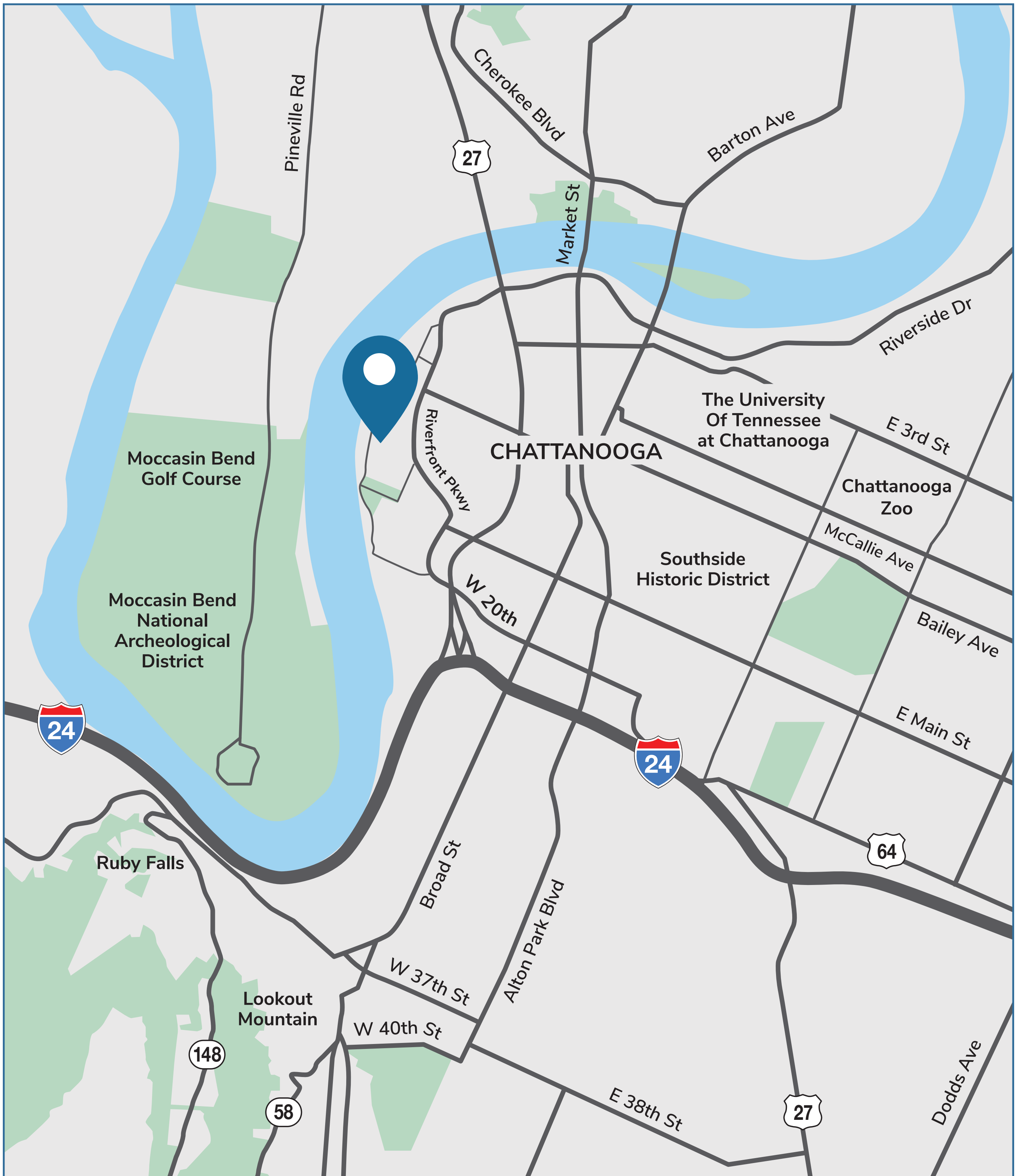
____

I certify that these services are medically necessary.

Signature: ____ Date: ____________

Healthcare Provider's Name *(Please print)*: ____

Credentials, i.e. MD, DDS, PA: ____



RiverRun HEALTH PHYSICAL THERAPY

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