



Realize YOUR Potential

PHYSICAL THERAPY REFERRAL

Date: _____

Patient Name: _____

Patient Phone Number: _____

Diagnosis: _____

Treatment: _____

Comments & Contraindications: _____

Rx Frequency: PRN Per Week for Weeks

Procedures & Modalities: Per Therapist Judgment

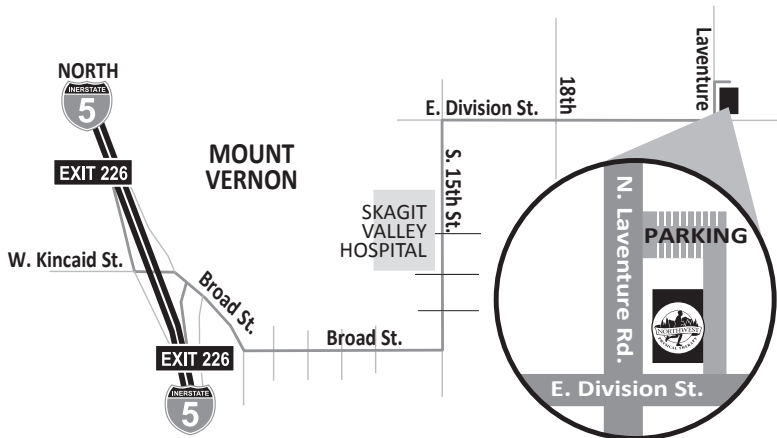
- | | | |
|--|---|-------------------------------------|
| <input type="radio"/> Evaluation/Consultation | <input type="radio"/> Industrial Rehabilitation | <input type="radio"/> Traction |
| <input type="radio"/> Mobilization/Manual Therapy | <input type="radio"/> PCE | <input type="radio"/> Cervical |
| <input type="radio"/> Vestibular Rehab | <input type="radio"/> Work Conditioning | <input type="radio"/> Lumbar |
| <input type="radio"/> Myofascial Release/Massage | <input type="radio"/> Work Hardening | <input type="radio"/> Phonophoresis |
| <input type="radio"/> Gait Training/Biomechanical Assessment | <input type="radio"/> Modalities | <input type="radio"/> Rx: _____ |
| <input type="radio"/> Posture/Spine Education | <input type="radio"/> Ultrasound | <input type="radio"/> Iontophoresis |
| <input type="radio"/> Return to Sport/Life | <input type="radio"/> Contrast | <input type="radio"/> Rx: _____ |
| <input type="radio"/> Strengthening/HEP | <input type="radio"/> Hydrotherapy | <input type="radio"/> Other: _____ |
| <input type="radio"/> Urogynecology | <input type="radio"/> Electrical Stimulation | _____ |
| <input type="radio"/> Women's Health | <input type="radio"/> TENS | _____ |
| <input type="radio"/> Men's Health | | |

Physician Signature: _____

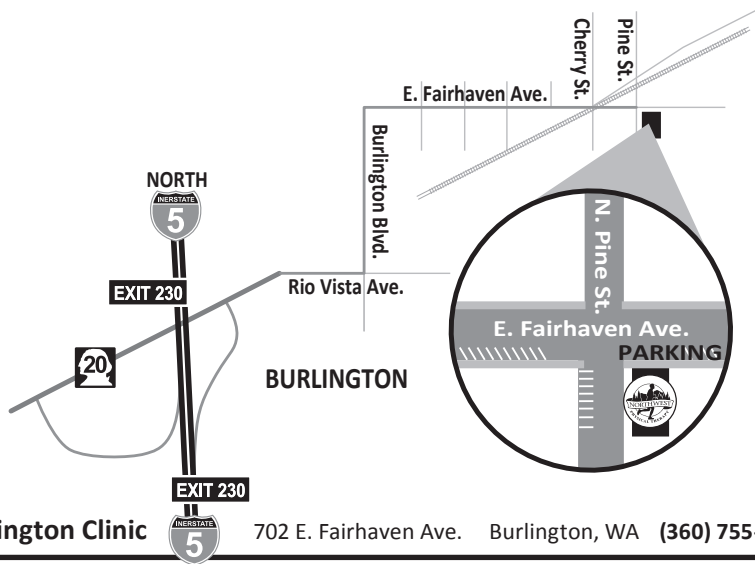
LaVenture Clinic
110 N. LaVenture Rd., Suite A
Mount Vernon, WA
(360) 428-2700
Fax: (360) 428-2701

Burlington Clinic
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Burlington, WA
(360) 755-9111
Fax: (360) 755-1320

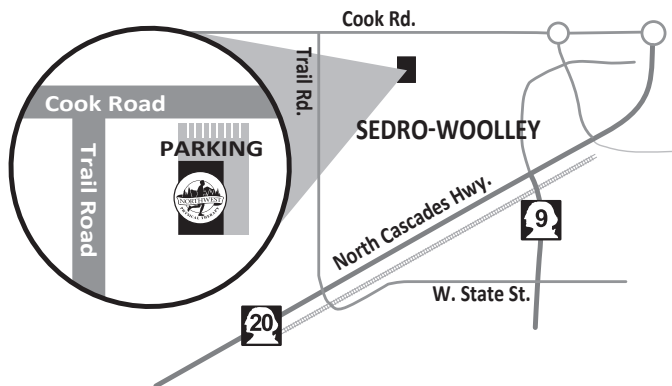
Sedro-Woolley Clinic
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