capstone
physical therapy

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Referral

Patient Name _____ Phone Number _____

Diagnosis _____ ICD CODE _____

Date of Injury _____ Date of Surgery _____

◯ Therapist evaluate and determine use of procedures, modalities, and / or frequency of treatment

◯ Precautions _____

PHYSICAL THERAPY PROCEDURES
___ ROM/ Strength/ Function
___ Manual Therapy
___ Gait/ Balance
___ Education (ergonomics/ posture)
___ Home Exercise
___ ADL Retraining
___ Splint/ Orthotics_____

___ **MASSAGE THERAPY**

___ **SPEECH THERAPY**

___ **OCCUPATIONAL THERAPY**

INDUSTRIAL REHAB
___ Work Conditioning
___ Work Hardening
___ Job Site Assessment
___ PCE/ FCE
___ Body Mech Eval/ Training

SPECIAL PROGRAMS
___ Vestibular Rehab
___ Balance Retraining
___ Home Safety Evaluation
___ Fall Risk Reduction
___ Women's Health/ Incontinence/Pelvic Pain
___ AlterG Anti-Gravity Treadmill
___ Sport Conditioning

Treatment Frequency _____ x-per week or _____ weeks, or _____ PRN
Physician Recheck Date _____

Physician Signature _____ Date _____

Print Name _____

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Lynden, WA 98264
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F. 360.354.0321

◯ Bellingham
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Suite 101
Bellingham, WA 98226
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F. 360.752.3210

◯ Ferndale
1740 Labounty Dr
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T. 360.384.5111
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◯ Blaine
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