PATIENT REFERRAL FORM

Date: / /

☐ 16610 107th st ORLAND PARK, IL 60467

(708) 364-7500 Phone
(708) 364-7555 Fax

Thank You For This Referral

PATIENT INFORMATION

Patient's Name: _____

Patient's Phone: _____

Diagnosis/Surgical Procedure: _____

Precautions: _____

Physical Therapy Services

- ☐ Evaluate and Treat
- ☐ Manual therapy
- ☐ Therapeutic Exercise
- ☐ Neuromuscular Reeducation
- ☐ Electrical Stimulation
- ☐ Ultrasound
- ☐ Hot/ Cold Packs.
- ☐ Laser/ Light therapy
- ☐ Gait Training
- ☐ Modalities for symptom relief
- ☐ Iontophoresis
- ☐ Traction
- ☐ Orthotics
- ☐ Neuropathy program
- ☐ Stroke Rehabilitation
- ☐ Spinal Rehabilitation
- ☐ Balance/ Coordination
- ☐ Home Exercise Program

Physical Therapy Services

- ☐ Work Hardening Program (5 x Week)
- ☐ Work Conditioning Program (3 x Week)
- ☐ Firefighter/Police Program (5 x week)

Physical Therapy Services

Frequency _____x week for _____weeks

_____
Next MD Visit

_____
Provider (print)

_____
MD Telephone Number

_____
Provider Signature

_____
Date