Balanced Rehab
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OUTPATIENT REFERRAL FORM

Patient Name: ______________________________ DOB ____________ Phone ______________

Diagnosis ___________________________________ Date of Injury/Illness/Surgery ____________

Precautions/Contraindications ____

PHYSICAL THERAPY

_√_ **Evaluate and Treat**
___ Therapeutic Exercise
___ Manual Therapy
___ Isokinetic Test/ Exercise
___ Myofascial Release/Massage
___ Hot Packs/Ice Packs
___ Electrical Stimulation
___ Ultrasound
___ Mechanical Traction
___ Gait Training
___ Equilibrium Training
___ Vestibular Rehab
___ Manual Lymphatic Drainage
___ Neuromuscular Re-education

Other: ____
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Goals

___ Relieve Pain
___ Increase ROM
___ Independence in Home Program
___ Improve Function
___ Improve Strength

Frequency: ____________________ Duration: __________________ Rehab Potential: ______________

Physician: ___________________________________ Date: _________________________

P.I.D. ____

Please fax orders to 386-252-2414