Medical Center Physical Therapy, Inc.

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PHYSICAL THERAPY CONSULTATION

Referral for Services

Date: _____

Patient Name: _____ Patient Phone: _____

Diagnosis: _____

☐ EVALUATE & TREAT AS INDICATED

Frequency of Treatments: ☐ qw ☐ biw ☐ tiw Other: _____

Duration of Treatments: _____ Week(s) *or* _____ Month(s)

☐ Other Instructions: _____

☐ Precautions: _____

Additional Clinical Services

(Check as appropriate)

☐ Work Hardening/Work Conditioning (to be determined by FCE)
☐ Functional Capacity Evaluation
☐ Isokinetic Extremity Joint Testing
☐ Job/Worksite Evaluation
☐ Pre-Placement Screening
☐ Fit for Duty Evaluation

Goals: _____

Physician Signature: _____ Printed Name: _____

Please sign and fax to (210) 692-7079 ~ Thank you!