XCEL PHYSICAL THERAPY & WELLNESS CENTER

Physician Referral / Physical Therapy Order Form

Patient referral and therapy treatment request

PATIENT INFORMATION

Patient Name

Phone Number

Date of Birth

Diagnosis

Notes / Precautions

SERVICE REQUESTS

Musculoskeletal Rehab & Pain Management

- ☐ Evaluate & Treat
- ☐ Post-Op Rehab
- ☐ Low Back Pain & Core Retraining
- ☐ Cervical Rehab
- ☐ Shoulder Rehab
- ☐ Elbow & Wrist Rehab
- ☐ Hip Rehab
- ☐ Knee Rehab
- ☐ ACL Rehab
- ☐ Ankle & Foot Rehab
- ☐ Sciatic Pain

Other _____

Balance & Fall Prevention

- ☐ Evaluate & Treat
- ☐ Generalized Weakness
- ☐ De-Condition / Atrophy
- ☐ Peripheral Neuropathy
- ☐ Post-CVA
- ☐ BPPV / Vestibular
- ☐ Fall Risk Program
- ☐ Postural Instability / Pain

Other _____

Modalities

- ☐ Electric Stimulation
- ☐ Ultrasound
- ☐ IASTM (Instrument-Assisted Soft Tissue Mobilization)
- ☐ Red Light Therapy
- ☐ Cold/Thermal (Moist Heat)
- ☐ Biofeedback

Other _____

Pelvic Floor Assessment

☐ Evaluate & Treat
☐ Biofeedback for Stress/Urge Incontinence

Concussion Evaluation

☐ Evaluate & Treat

TREATMENT PLAN

Frequency

Duration (Weeks)

PHYSICIAN INFORMATION

Physician Name

Physician Email

Physician Phone

Fax (Optional)

NPI (Optional)

Date

Signature