WEST RICHLAND
PHYSICAL THERAPY

PHYSICAL THERAPY REFERRAL

West Richland Physical Therapy
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Date: ____________________ ICD-9 Code: ________________

Name: ____
Diagnosis: ____
Surgical Procedure: ____________________________________
RX FREQUENCY ______________ per week ______________weeks

☐ **EVALUATE AND TREAT**

MODALITIES

- ☐ Modalities as needed
- ☐ Paraffin
- ☐ Electrical Stimulation
- ☐ Ultrasound
- ☐ Cervical Traction
- ☐ Lumbar Traction
- ☐ Whirlpool

PROCEDURES

- ☐ ROM/flexibility
- ☐ Strength and Conditioning
- ☐ Massage
- ☐ Joint Mobilization
- ☐ Balance and Coordination
- ☐ Therapeutic Exercise
- ☐ Gait Training
- ☐ Soft Tissue Mobilization
- ☐ Stroke rehabilitation
- ☐ Back rehabilitation
- ☐ Postural Training
- ☐ Throwing Mechanics
- ☐ Progressive resisted exercises
- ☐ Aerobic exercise
- ☐ Custom Foot Orthotics

INDUSTRIAL REHABILITATION

- ☐ Physical Capacity Evaluation
- ☐ Work Conditioning
- ☐ Back School
- ☐ Work Hardening

In signing this referral, physician certifies that physical therapy is medically necessary.

Precautions/Instructions:

Physician Signature:______________________________Date:__________