BELLEFONTAINE PHYSICAL THERAPY

REFERRAL FORM/PLAN OF CARE

PATIENT INFORMATION:

Name _____ Date _____

Diagnosis/condition _____

Surgical procedures/significant past history _____

TREATMENT GOALS:

Goal Potential:	Fair	Good	Excellent
☐ Increase strength	☐ Improve function	☐ Decrease edema	☐ Improve fitness
☐ Increase mobility	☐ Improve posture	☐ Decrease pain	

PHYSICIAN'S ORDERS:

☐ Evaluate and treat	☐ Cybex extremity ex/test	☐ Massage ice/soft tissue	☐ Traction
☐ Aerobic conditioning	☐ Electrical stimulation	☐ Mobilization	☐ Ultrasound
☐ Back school	☐ Exercise	☐ Orthotics	☐ Ultrasound/ES
☐ Biofeedback	☐ Fluidotherapy	☐ Paraffin bath	☐ Whirlpool
☐ Cold/hot packs	☐ Gait training	☐ Phonophoresis	☐ Work reconditioning
☐ Contrast baths	☐ Home instruction	☐ Pool	☐ Other
☐ Cybex back ex/test	☐ Iontophoresis	☐ TENS	

TREATMENT PLAN:

☐ Therapist's discretion

Frequency of treatment ____ day(s)/week. Duration of treatment ____ week(s).

PHYSICIAN'S SIGNATURE: _____ THANK YOU FOR THIS REFERRAL

Please use reverse side to list additional comments such as contraindications, results of previous physical therapy and extent the patient is aware of diagnosis and prognosis.

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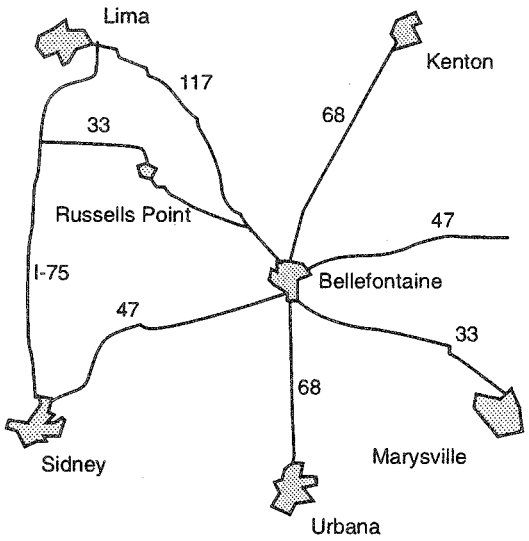
ADDITIONAL COMMENTS: _____



LOCATION:
711 RUSH AVE.