MPT
MOVEMENT PHYSICAL THERAPY

REFERRAL FOR PHYSICAL THERAPY

Patient Name _____ DOB _____

Patient Phone _____ Date _____

Diagnosis _____

Frequency: 1 2 3 4 5 x per week Duration: 1 2 3 4 6 weeks

THERAPEUTIC EXERCISE

- ☐ Passive ROM
- ☐ Active ROM
- ☐ Active Assisted ROM
- ☐ Progressive Resistive Exercise
- ☐ Strengthening
- ☐ Stabilization Program
- ☐ Posture/Body Mechanics
- ☐ Gait Training
- ☐ Fall Risk Assessment
- ☐ Home Exercise Program

MANUAL THERAPY

- ☐ Soft Tissue Mobilization
- ☐ Joint Mobilization
- ☐ Myofascial Mobilization
- ☐ Post Operative Rehabilitation Protocol for _____

Date of Surgery _____

NEUROMUSCULAR RE-EDUCATION

- ☐ Balance/Proprioceptive Training

MODALITIES

- ☐ Ultrasound
- ☐ Phonophoresis
- ☐ Iontophoresis
- ☐ Electrical Stimulation
- ☐ Mechanical Traction

SPORTS SPECIFIC TRAINING

OTHER _____

_____

_____

SPECIAL INSTRUCTIONS: _____

_____

The above plan of care is established and will be reviewed every 30 days.
I certify the medical necessity of therapy.

_____ _____

Physician's Signature: Date:

DO NOT EMAIL PRESCRIPTION The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.

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www.movementptwa.com

Snohomish
1830 Bickford Avenue, Suite 209
Snohomish, WA 98290
Tel 360.568.7774 Fax 360.568.7779

IMMEDIATE APPOINTMENTS 24-48 HRS
PERSONALIZED TREATMENT PLANS • MOST INSURANCES ACCEPTED

JUST A REMINDER

- Please bring this referral with you on your first visit
- Please arrive 15 minutes before your scheduled appointment to complete any necessary paperwork

WHAT TO WEAR

- Please bring comfortable clothing and wear short sleeves.

WHAT TO BRING

- Referral from your doctor
- Photo ID
- Insurance card
- For worker's injuries/L&I, please bring claim form

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