

**PHYSICAL
THERAPY
CARE & +
AQUATIC REHAB**

OF FORT BEND



LOCATIONS

RICHMOND

1500 Jackson Ste. #400, Richmond, TX 77469
P: 281.344.8900 | F: 281.344.8926

KATY/FULSHEAR

26440 FM 1093, Ste. #A180, Richmond, TX 77406
P: 281.347.8900 | F: 281.347.8906

PHYSICAL THERAPY REFERRAL & CONSULTATION

PATIENT NAME: _____ DATE: _____

PATIENT PHONE: _____ PATIENT DOB: _____

DIAGNOSIS/ICD CODE: _____

REQUEST: PT Evaluate and Treat Evaluation Only Pre-op Rehab Pediatric Neuro/Developmental Evaluation

FREQUENCY: _____ DURATION: _____

If you request selective intervention for this patient, indicate below:

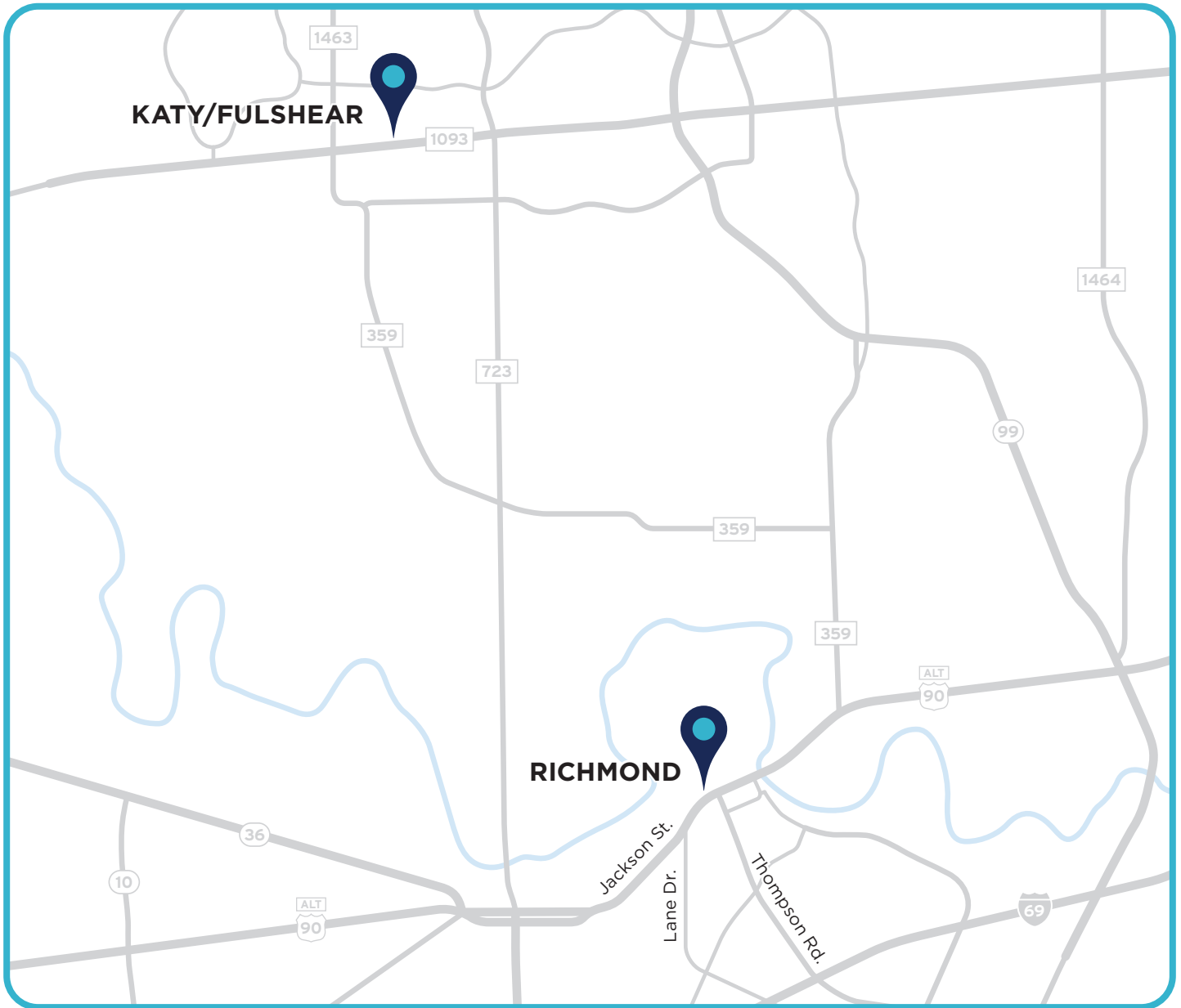
- | | | |
|--|--|--|
| <input type="checkbox"/> RANGE OF MOTION | <input type="checkbox"/> VESTIBULAR/ BALANCE/ BPPV | <input type="checkbox"/> AQUATIC THERAPY |
| <input type="checkbox"/> THERAPEUTIC EXERCISE | <input type="checkbox"/> MANUAL THERAPY | <input type="checkbox"/> METABOLIC/CARDIO CONDITIONING |
| <input type="checkbox"/> GAIT EVALUATION/ TRAINING | <input type="checkbox"/> SOFT TISSUE MOBILIZATION | <input type="checkbox"/> INJURY PREVENTION PROGRAM |
| <input type="checkbox"/> HOME EXERCISE PROGRAM | <input type="checkbox"/> TRIGGER POINT/ DRY NEEDLING | <input type="checkbox"/> KINESIOTAPE & ORTHOTICS |
| <input type="checkbox"/> TMJD | <input type="checkbox"/> TRACTION | |

MODALITIES: Electrical Stimulation TENS Ultrasound Infrared Ionto/Phonophoresis
(Please provide the medications for patient)

COMMENTS/ PRECAUTIONS: _____

REFERRING PROVIDER SIGNATURE: _____ PLEASE PRINT NAME: _____ DATE: _____

PT-CARE LOCATIONS



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