# CORE Physical Therapy - Provider Referral Print & Fax Form

CORE Physical Therapy
1410 Fretz Drive - Edmond, OK 73003
Fax 405-285-8499 Phone 405-285-8477

Referring Provider: ______________________________ Patient: ______________________________

Today's Date: ______________

Diagnosis: ______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________

Date of Surgery: ______________

Diagnosis Code(s): ____________________

Date of Next Scheduled Doctor's Appointment: ______________

☐ Evaluate & Treat (circle 1-10) Conservative 1 2 3 4 5 6 7 8 9 10 Aggressive

Evaluate & Treat for ______ visits per week for ______ weeks

Specific Instructions or Precautions:______________________________________________

______________________________________________________________

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| Therapeutic Exercises | Manual Therapy | Modalities |
| --- | --- | --- |
| ☐ PROM/AAROM/AROM | ☐ Joint Manipulation/Mobilization | ☐ Hot/Cold Pack |
| ☐ Strengthening | ☐ Soft Tissue Mobilization | ☐ Ultrasound |
| ☐ Flexibility | ☐ Myofascial Release | ☐ Electrical Stimulation |
| ☐ Neuromuscular Re-ed | ☐ Other ______________ | ☐ NMES |
| ☐ Proprioceptive Training | | ☐ Traction/Unloading |
| ☐ Gait Training | | ☐ Aquatics |
| ☐ Pre-op Excercise | | ☐ Ionto/Phono (sign below) |
| ☐ Other ______________ | | ☐ Other ______________ |

☐ Iontophoresis: Dexamethasone 4 mg / ml, 1-2cc per treatment for _____ treatments

☐ Phonophoresis: Hydrocortisone 10% / aquasonic gel 20 gms with _____ refills

Prescribing Physician's Signature ______________________________

I certify that the prescribed treatment is an appropriate course and the services prescribed are medically necessary.

Physician Signature ______________________________