HOME AND OUTPATIENT BASED THERAPY PROVIDER
3475 W ALTON GLOOR BLVD, SUITE D, BROWNSVILLE, TEXAS 78520
PHONE: 9563502143, FAX: 9563503744, EMAIL: EMAILUS@VALLEYHEALINGHANDS.COM

THERAPY REFERRAL FORM

PHYSICIAN: **PHONE :**

PATIENT'S NAME: **D.O.B:**

CONTACT DETAILS:

THERAPY: **PT** **OT** **ST** **FREQUENCY:**

TO BE PROVIDED AS: HOME HEALTH THERAPY **OUTPATIENT THERAPY**

Evaluate and treat **Evaluate and return**

DIAGNOSIS:

Cervicalgia: Lumbago: Sciatica: Strain/Sprain:
Pain in shoulder/elbow/wrist/hip/knee/ankle: Gait Impairments: Balance:
Muscle weakness: Transfer training: Home safety evaluation:
AD Equipment assessment/Modification/training: UE/LE Fracture Rehab:
Tendinitis/Bursitis: Functional Capacity Evaluation:
Other/Comments/Protocols/Precautions:

Surgical:

Cervical Spinal Surgery rehab: Lumbar spinal surgery rehab:
Hip/Knee replacement rehab: Amputation Rehab:
Other/Comments/Protocols/Precautions:

Goals:

Reduce pain: Improve ROM: Improve Strength: Improve Balance:
Improve Transfers: Improve Gait: Improve Endurance: Breathing exs:
Lymphedema drainage:
Other/Comments:

Modalities suggested:

Iontophoresis: Ultrasound: Muscle stimulation: Cold Laser:
Other/Comments:

Instructions/Comments:

Signature: **Date:**

Thank you for your referral
Please fax this form to 9563503744