Physical Therapy Referral

DATE: [Date]

TO (PHYSICAL THERAPIST/CLINIC):
[Clinic Name]

[Provider Name, if applicable]

[Phone/Fax Number]

FROM (REFERRING PROVIDER):
[Provider Name]

[Practice Name]

[NPI Number]

PATIENT INFORMATION:
NAME: [Patient Full Name]

DOB: [Date of Birth]

PHONE: [Contact Number]

INSURANCE: [Provider & Member ID]

CLINICAL INFORMATION:
ICD-10 DIAGNOSIS: [Code and Description]

ONSET DATE/SURGERY DATE: [Date]

EVALUATION & TREATMENT ORDERS:

[ ] Evaluate and Treat
[ ] Specific Protocol: ____________________
[ ] Frequency: ____ days/week for ____ weeks

PRECAUTIONS / CONTRAINDICATIONS:

[Weight bearing status, ROM limitations, or relevant comorbidities]

PHYSICIAN SIGNATURE