COAST
PHYSICAL THERAPY SPECIALISTS

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Physical Therapy Referral Information

Patient's Name: _____ Birthdate: _____

Address: _____

Phone: (Home) _____ (Cell) _____

Insurance Type: ☐ *Medicare* ☐ *Private* ☐ *HMO* ☐ *PPO*

Diagnosis/Impression/Chief Complaint: _____
(Please include copy of operative report if available)

_____

ICD-10 Code: _____

Surgery Performed: _____ Date: _____

Lab/X-Ray/MRI Findings: _____

_____

_____

Suggested Treatment:

- ☐ *Physical therapy evaluation, assessment and plan*
- ☐ *Treatment as indicated by physical therapy evaluation (manual therapy, training precedures and modalities as indicated)*
- ☐ *Biomechanical analysis and custom foot orthotic fabrication*
- ☐ *Orthotic device (specify)* _____
- ☐ *Special tests (specify)* _____

Special instructions/precautions: _____

_____

_____

Treatment Goals:

- ☐ *Decrease pain*
- ☐ *Promote relaxation/decrease spasm*
- ☐ *Increase functional range of motion*
- ☐ *Increase functional stabilization/dynamic control*
- ☐ *Increase overall function level*
- ☐ *Return to work or activity*
- ☐ *Increase strength*
- ☐ *Other*

Rehabilitation Potential:

- ☐ *Excellent*
- ☐ *Good*
- ☐ *Fair*
- ☐ *Poor*

Daily 3X/WK 2X/WK 1X/WK No. of Weeks: _____

Date of return appointment with Physician: _____

_____ MD _____

Physician's Signature Date