HEALTHCARE PRACTITIONER REFERRAL FORM

ATLAS PHYSICAL THERAPY

3636 Executive Center Drive
Suite 150
Austin, TX 78731

Ph: 512-795-0053
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www.atlaspt.net

Patient: _____ Date: _____

Diagnosis / Procedure: _____

Precautions or Specific Requests: _____

WT. BEARING STATUS:	☐ Full	☐ Toe	☐ Touch	☐ Partial _____% ☐ NWB
MEDICAL INFORMATION:	☐ ↓ Swelling	☐ ↑ ROM		
	☐ Pre op	☐ Post op	☐ Pain Level: 1 2 3 4 5 6 7 8 9 10	
WORK STATUS:	☐ Full Duty	☐ Light Duty	☐ None	

☐ **EVALUATE & TREAT**

☐ **TREAT ONLY AS SPECIFIED BELOW**

MANUAL THERAPY

__ Soft Tissue
__ Joint Mobilization
__ Manual Traction
__ Myofascial Release
__ Scar Mobilization

MODALITIES

__ Cold Pack/ Moist Heat
__ Ice Massage
__ Paraffin Bath
__ Electrical Stimulation
__ Neuromuscular Re-education
__ Gait Training
__ Ultrasound
__ Iontophoresis (*medication Rx required*)
__ Phonophoresis
__ T.E.N.S. (*Rental / Purchase*)
__ N.M.E.S. (*Rental / Purchase*)

THERAPEUTIC EXERCISE

__ Passive ROM
__ Active Assistive ROM
__ Active ROM
__ Resistive
__ Isometric

HOME EXERCISE PROGRAM

__ Flexibility/ Stretching
__ Isometrics
__ Strengthening
__ Theraband
__ Pre Op/Post Op Program

PROTOCOLS

__ Shoulder
__ Elbow
__ Wrist
__ Hip
__ Knee
__ Ankle
__ Foot
__ Back
__ Neck
__ Balance Training
__ Gait Training
__ Spinal Stabilization
__ McKenzie Rehab
__ Patellofemoral
__ McConnell Taping

FREQUENCY:	☐ 1 x weekly	☐ 2 x weekly	☐ 3 x weekly	☐ Daily
DURATION:	☐ 1 week	☐ 2 weeks	☐ 3 weeks	☐ 4 weeks

THIS PRESCRIPTION IS AN EVALUATE AND TREAT ORDER UNLESS SPECIFIED ABOVE.

I CERTIFY THAT THE ABOVE TREATMENT PLAN IS MEDICALLY NECESSARY AND IS APPROVED.

Signature: _____ Date: _____

Printed Name: _____ Date: _____