Alternative Back Care

Physical Therapy • Achieving relief one patient at a time.

3502 S. 12th Street, Suite B • Tacoma, Washington 98405
(253) 564-2220 • www.abcphysicaltherapy.com

REFERRAL FORM

Patient _____

Patient Phone Number _____ Date _____

Diagnosis/ICD-9 _____

Precautions/Remarks _____

_____

_____

_____

Instructions: ☐ Evaluate & Treat

Modalities:

☐ Heat	☐ Cold	☐ Contrast
☐ Electrical Stimulation	☐ Ultrasound	☐ Phonophoresis
☐ Iontophoresis*	☐ Massage	
☐ Fall Protection	☐ Frictional Massage	

Procedures:

☐ Mobilization	☐ Gait Training	☐ ROM / Flexibility
☐ Therapeutic Exercise	☐ Gait Analysis	☐ Traction

Treatment Plan: ☐ Therapists Discretion

Frequency/Duration: _____ Times Per Week For _____ Weeks

Additional Comments: _____

_____

_____

_____

_____

Physician's Signature: _____

Thank you for this referral!