



Physical Therapy & Rehab Concepts

www.ptrc-tx.com / ptrc@centurytel.net

San Marcos
915 Hwy. 80
San Mar Plaza
San Marcos, TX 78666
(512) 353-4575
(512) 353-4580 Fax
1-800-511-3080

Wimberley
14306 Ranch Rd. 12, Ste. 9
Y-Center
Wimberley, TX 78656
(512) 847-9057
(512) 847-8602 Fax

PHYSICAL THERAPY REFERRAL

PATIENT: _____ DATE: _____

DIAGNOSIS: _____

DOS: _____ DOI: _____

FOLLOW-UP DATE: _____ PRECAUTIONS: _____

EVALUATIONS: Eval & Treat, FCE, Orthotics, Other: _____

TREATMENT GOALS: Decrease Pain, Decrease Swelling, Inc. ROM, Inc. Strength,
 Inc. Independence, Other

PROTOCOLS: ACL, Hand/Tendon, Wound, Other: _____

THERAPEUTIC EXERCISE: As per Therapist, Progressive Resistive, Passive ROM, Active Assisted ROM, Active ROM, Closed Chain, Other: _____

MODALITIES: As per Therapist, U.S., Phonophoresis, Moist Heat, Cold/Ice
 Iontophoresis, Traction, E-stim/TENS, Massage,
Other: _____

PROGRAMS: Pool Therapy, Work Hardening, Work Conditioning, Back School,
 Gait Training (____%WB), Home Exercise Program,
Other: _____

FREQUENCY: 1x/wk 2x/wk 3x/wk 4x/wk 5x/wk qd qod

DURATON: 1 week 2 weeks 3 weeks 4 weeks ____ weeks

Then: _____ w/week

Physician Signature

Date

In making this referral, Physician certifies that prescribed treatment is a medical necessity.

For Detailed Clinic Locations Go To Website – www.ptrc-tx.com