Carolina Strong
PHYSICAL THERAPY

Carolina Strong Physical Therapy
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Southport, NC 28461
Office 910-375-5748
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REFERRAL FOR PHYSICAL THERAPY

Patient Name_____ Date_____

Medical Diagnosis_____

Surgical Diagnosis_____

Precautions/Restrictions_____

☐ **Physical Therapy Evaluate and Treat** ☐ **Treatments at Therapist's discretion**

THERAPEUTIC EXERCISE

- ☐ AROM/PROM/AAROM
- ☐ Strengthening
- ☐ Stretching
- ☐ Stabilization: core/joint
- ☐ Isometrics
- ☐ Gait Training
- ☐ Conditioning

MODALITIES

- ☐ Modalities at Therapist discretion
- ☐ Ultrasound
- ☐ Electric stim
- ☐ Combo US/Stim
- ☐ Moist Heat
- ☐ Cryotherapy
- ☐ Traction
- ☐ Parafin

MANUAL THERAPY

- ☐ Mobilization/Manipulation
- ☐ STM/DTM/MFR
- ☐ MET (Muscle energy techniques)
- ☐ Strain/Counter-strain

OTHER

- ☐ Taping
- ☐ Orthotics

SPECIALTY PROGRAMS

- ☐ Functional Dry Needling
- ☐ Neuromuscular Therapy
- ☐ ASTYM/SASTM (Augmented soft tissue mobilization/Sound assisted soft tissue mobilization)
- ☐ SFMA/FMS (Selective Functional Movement Assessment/Functional Movement Screening)
- ☐ Vestibular Rehab: BPPV
- ☐ Neuromuscular Re-ed

☐ Home Exercise Program

Frequency of Treatment 1 2 3 4 5 days/week for 2 4 6 8 _____ Weeks

Additional Comments:

Date:_____ **Physician Signature**_____

(My signature authorizes this treatment to be medically necessary)