Carolina Strong Physical Therapy
4002 Executive Park Blvd, Suite 800
Southport, NC 28461
Office 910-477-6236
Fax 910-477-6357

Referral for Physical Therapy

Patient Name: ______________________________

Address: ______________________________

Patient's Phone Number: ______________________________

Date of Birth: ______________________________

Referring Doctor: ______________________________

Doctor's Phone Number: ____________________ Fax Number: ______________

Primary Insurance: ____________________ Sub # ______________

Secondary Insurance: ____________________ Sub # ______________

Medical Diagnosis: ______________________________

Surgical Diagnosis: ______________________________

Precautions/Restrictions: ______________________________

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_____ Physical Therapy Evaluate and Treat ____ Treatment at Therapist's discretion

THERAPEUTIC EXERCISE

__AROM/PROM/AAROM

__Strenghthening
__Stabilization: core/joint
__Isometrics
__Gait Training
__Conditioning

MODALITIES

__Modalities at Therapist's discretion

__Electric Stim
__Combo US/Stim
__Moist Heat
__Cryotherapy
__Traction
__Parafin

Manual Therapy

__Mobilization/Manipulation

__MET (Muscle Energy Tech)
__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/weeks for 2 4 6 8 ____ weeks

Date: ________________ **Physician's Signature:** ______________________________
(My signature authorizes this treatment to be medically necessary)