Pro-PT

Professional Physical Therapy Services

Mary Beth Jenkins, PT
1207 South Cox Street Suite C
Asheboro, NC 27203
Phone: 336-267-9596 Fax 336-625-0777

Appointment Date:_____
Appointment Time:_____

Physical Therapy Referral Form

PATIENT NAME:_____ DATE: _____
PHONE NUMBER: _____ DOB: _____ INSURANCE_____
INSURANCE SUBSCRIBER/GROUP #:_____
DIAGNOSIS:_____ICD-9 Code : _____

FREQUENCY (Per Week)	1	2	3	4	5	AS NEEDED	
DURATION (Weeks)	1	2	3	4	5	6	AS NEEDED

_____ Evaluate and Treat
_____ Evaluate and HEP Only

Exercise
_____ROM Exercise
___Passive ____Active-Assistive
___Active ____Resistive
_____ Strengthening/Conditioning
_____ Spine Rehabilitation/Stabilization

Modalities
_____Hot/Cold Packs
_____ Ultrasound
_____Electrical Stim/TENS
_____Iontophoresis
w/Dexamethasone
_____Dosage 40/60/80 MA.min
_____Pain Management

Manual Therapy
_____ Massage/Soft Tissue Mobilization
_____ Joint Mobilization

Functional Activities
_____ Gait Training/WBS_____
_____ Transfer Training
_____ ADL Training

Other Instructions/Treatments: _____

Treatment Goals/Precautions: _____

By signing this prescription, the physician certifies medical necessity

Signature : _____