PHYSICAL THERAPY REFERRAL

FOUNDATION PHYSICAL THERAPY

Patient Name: _____

Date: _____

Date of Birth: _____

Patient Phone #: _____

LEON SPRINGS
phone | 210.698.6333
fax | 210.698.6332

BOERNE
phone | 830.816.5333
fax | 830.816.5332

Diagnosis/ICD10: _____

THERAPY SERVICES REQUESTED

☐ Evaluate and Treat

- ☐ Manual Therapy
- ☐ Therapeutic Exercise
- ☐ Neuromuscular Re-Education
- ☐ Gait Training/Analysis
- ☐ Electrical Modalities

☐ Weight Bearing: _____

☐ Dry Needling: _____

☐ Blood Flow Restriction Training: _____

☐ Functional Movement Screen: _____

☐ Special Instructions: _____

_____

DOS: _____

Freq: _____ / Weeks: _____

Physical therapy is medically necessary to restore patient functionality and decrease medical costs.

Physician's Name (printed): _____

Authorizing Signature: _____ Date: _____

INSTRUCTIONS FOR NEW PATIENTS

Verify Appointment:

Date: _____ Time: _____

What to bring:

- Physical Therapy Referral
- Proper Attire (work out clothes)
- Drivers License
- Insurance Card
- List of Medications
- X-Ray / MRI Reports
- Parent/Guardian (if under 18)
- Co-Pay

Please arrive 15 min early to your first appointment to complete paperwork.

OFFICE LOCATION

BOERNE

North Main Plaza
905 N. Main St., Suite 103
Boerne, Texas 78006

LEON SPRINGS

The Domain Plaza
23127 IH-10 West, Suite 203
San Antonio, Texas 78257