PHYSICAL THERAPY REFERRAL

Patient Name: _____

Date of Birth: _____

Patient Phone #: _____

Diagnosis/ ICD 10: _____

_____

THERAPY SERVICES REQUESTED

☐ Evaluate and Treat

☐ Manual Therapy

☐ Therapeutic Exercises

☐ Neuromuscular Re-education

☐ Gait Training

☐ HEP

☐ Electrical Modalities

Weight Bearing: _____

Special Instruction: _____

_____

_____

_____

DOS: _____

Freq: _____ / Weeks: _____

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

Physician's Name (printed): _____

Physician's Signature: _____ Date: _____

Foundation Physical Therapy Locations

☐ **Leon Springs Location**

Domain Plaza Center

23127 IH-10 West, Suite 203

San Antonio, Tx 78257

(ph) 210-698-6333

(fx) 210-69806332

☐ **Boerne Location**

North Main Plaza Center

905 N. Main St, Suite 103

Boerne, Tx 78006

(ph) 830-816-5333

(fx) 830-816-5332