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NORTH COUNTY
Water and Sports
THERAPY CENTER

Referral for Physical Therapy

Patient Name: _____ Date: _____

Diagnosis: _____

Precautions/Comments: _____

- ❑ *Evaluation and Treatment*
- ❑ *Home Exercise*
- ❑ *Aquatic Therapy*
- ❑ *Soft Tissue Mobilization/Massage*
- ❑ *Exercise*
  - ❑ *Passive ROM*
  - ❑ *Active*
  - ❑ *Resistive/Strengthening*
- ❑ *Modalities*
  - ❑ *Heat*
  - ❑ *Cold*
  - ❑ *Ultrasound/Phonophoresis*
  - ❑ *Electrical Stimulation*
  - ❑ *Iontophoresis*
- ❑ *Functional Training*
  - ❑ *Posture/Body Mechanics*
  - ❑ *Spine Stabilization*
  - ❑ *Gait Training*
  - ❑ *Closed Kinetic Chain/Balance/Proprioception*
  - ❑ *Sport Specific*
  - ❑ *Conditioning*

Frequency: _____ / week Duration: _____ week

Physician Signature: _____