THE BODY CENTER
PHYSICAL THERAPY AND PILATES

PHYSICAL THERAPY TREATMENT REFERRAL

Patient's Name: _____

Diagnosis: _____

DOB: _____

Precautions: _____

Physical Therapy Programs

- ☐ Balance / Fall Prevention Program
  - Comprehensive Balance Assessment
  - Progressive balance activity program
  - Assistive device fitting and training
- ☐ Pelvic Floor PT Program
  Computer assisted biofeedback exercise rehabilitation program for incontinence/pelvic floor dysfunction.
- ☐ Alter G- Anti Gravity Treadmill Programs
  - Reduce joint load activity program
  - Cardiopulmonary rehab graded activity program
  - Obesity reduction graded activity program
  - Speed performance program
- ☐ Pain Neuroscience Education Program
  12 sessions of graded exercise activity coupled with Pain Neuroscience Education for patients with persistent pain.
- ☐ Custom Foot Orthotic Program
  4 session program that consists of Foot/Ankle orthotic eval and casting. 2 sessions of PT and exercise prescription progression. Final fitting session and Home Program.
- ☐ High Performance Rehab Program
  - Add on program to for any patient with rehabilitation goals that require high levels of conditioning and performance.
  - Blood Flow Restriction & Cupping
  - TRX based training options
  - Plyometric Performance Training

Specialty Programs

- ☐ Arthritis / Joint Pain
- ☐ Back & Neck Pain
- ☐ Balance Problems
- ☐ Chronic Pain
- ☐ Degenerative Joint / Disc Disease
- ☐ Diabetic Peripheral Neuropathy
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Hip Pain (Arthritis, Labral Injuries)
- ☐ Hand Injuries / Pain (Carpal Tunnel Syndrome, Wrist Injuries)
- ☐ Incontinence / Pelvic Floor Dysfunction
- ☐ Knee Pain (Arthritis, Meniscus Injuries, Ligament sprain)
- ☐ Neurological Disorders
- ☐ Pre / Post Surgical Patients
- ☐ TMJ Pain / Headaches
- ☐ Shoulder Pain (Rotator cuff injuries, Labral injuries, Instabilities)
- ☐ Vestibular Rehabilitation
- ☐ Work Injury/Return To Work

Special instructions: _____

Physical Therapy Eval & Treat

Frequency / Duration: _____ time(s) per week for _____ ☑ week(s) ○ month(s).

I certify that the patient listed above is under my care and that the rehabilitation listed above is medically necessary for the health of the patient and must be provided by a skilled therapist.

Signed: _____ Date: _____

Print Name: _____ NPI: _____

Phone: _____ Fax: _____