HANDS ON THERAPY
physiotherapy clinic

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PATIENT REFERRAL

Name: _____ **D.O.B:** **(MM/DD/YYYY)** _____
Contact Numbers: (H)_____**(W)**_____**(C)**_____
Diagnosis: _____
Precautions/X-rays or Special Test: _____

EVALUATE AND TREAT

Modalities

- □ Ultrasound
- □ Electrical Stimulation-TENS
- □ Biofeedback/VMO training
- □ Kinesio-Taping
- □ Therapeutic Exercise/Stabilization Stretching
- □ Mobilization/ Mobilization with movement
- □ Myofascial Release
- □ Visceral Mobilization
- □ Craniosacral Therapy
- □ Postural Retraining
- □ Postural Taping

The Spine

- □ Osteoporosis Management
- □ Post-Surgical Care including Core Stabilization/Biomechanics
- □ McKenzie Extension Program
- □ Pilates
- □ Postural Muscle Assessment
- □ Spinal Mobility Exercises

Newborns

- □ Head and Face Shaping
- □ Torticollis

TMJ Treatment/Education

- □ Myofascial Release
- □ Stabilization Exercises

Athletes

- □ Pelvic balancing
- □ Injury Care/Prevention

Women's Health

- □ Pre/Post-partum care/education
- □ Well-Mom Visits
- □ Labor TENS
- □ Pelvic Floor Evaluation/Treatment
- □ Pelvic Pain
- □ Dyspareunia/Vaginismus
- □ C-section/Episiotomy Scar Release
- □ Interstitial Cystitis
- □ Incontinence Treatment
  - ○ Bladder retraining
  - ○ PFS
  - ○ Biofeedback
  - ○ Exercises
  - ○ Intravaginal Myofascial Release
- □ Pre/post OP OBGYN Surgeries
- □ Post Mastectomy
- □ Scar Management s/p Surgery

THANK YOU FOR YOUR REFERRAL

Referring Physician: _____
Date: _____
Phone: _____**Fax:**_____