genesis PHYSIOTHERAPY

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PHYSIOTHERAPY REFERRAL

PATIENT'S NAME ____

DATE OF BIRTH ____

DIAGNOSIS ____

REFERRING DOCTOR ____

DATE ____

ESTIMATED NUMBER OF SESSIONS ____

SPECIAL ORDERS ____

MODALITIES & PROCEDURES (please indicate)

- ❍ HEAT/ICE
- ❍ ULTRASOUND
- ❍ STRENGTHENING
- ❍ ROM
- ❍ GAIT TRAINING
- ❍ MASSAGE/MFR
- ❍ MECHANICAL TRACTION
- ❍ MANUAL TRACTION
- ❍ ELECTRICAL STIMULATION
- ❍ TENS
- ❍ NEUROMUSCULAR REEDUCATION
- ❍ DIAGNOSTIC EVALUATION
- ❍ STRAPPING
- ❍ ACCUPRESSURE
- ❍ STROKE REHABILITATION
- ❍ AMPUTEE REHABILITATION
- ❍ JOINT REPLACEMENT REHABILITATION
- ❍ GENERAL CONDITIONING
- ❍ WHEELCHAIR MANAGEMENT
- ❍ MIGRAINE EVALUATION
- ❍ OSTEOPATHIC MANIPULATION
- ❍ PRENATAL PAIN RELIEF

DOCTOR'S SIGNATURE ____

Hannah Foster-Middleton
BSc (Hons) Physiotherapy, MCSP, SRP

THANK YOU FOR YOUR REFERRAL