Physical Therapy Referral Form

CompletePT
POOL & LAND PHYSICAL THERAPY

Patient Name: _____

Diagnosis _____

Date of Injury _____ Next MD. Appt._____

☐ EVALUATE & TREAT

Rx Frequency: _____ days/week for _____ weeks.

Precautions: _____

_____

☐ POOL THERAPY

- ☐ POOL EXERCISES
- ☐ GAIT TRAINING
- ☐ RANGE OF MOTION
- ☐ STRENGTH TRAINING
- ☐ FLOATING TRACTION
- ☐ OTHER:_____

_____

☐ LAND THERAPY

- ☐ EXERCISES
- ☐ SOFT TISSUE MOBILIZATION
- ☐ JOINT MOBILIZATION
- ☐ RANGE OF MOTION
- ☐ STRENGTH TRAINING
- ☐ GAIT TRAINING
- ☐ MODALITIES
- ☐ OTHER:_____

I verify that physical therapy is medically necessary for this patient, that rehabilitation services will be rendered while the patient is under my care, and that the established treatment plan will be reviewed every thirty days as the patient's condition requires.

MD Signature: _____ Date: _____

MD Name (print): _____ Phone: _____

CompletePT
3283 Motor Avenue
Los Angeles, CA 90034

310/845-9690
Fax: 310/845-9691

www.CompletePT.com
info@CompletePT.com

- *Medicare and Private insurance accepted.*
- *Blue Cross, Blue Shield providers*

Katey Eisenstein, DPT
Daniel Leib, DPT
Mallory Withiam, DPT
Stephanie Jun, DPT
Steven Silverio, DPT
Jessica Bufete, DPT
Maytal Shay, DPT

Physical Therapy Referral Form

CompletePT
POOL & LAND PHYSICAL THERAPY

Patient Name: _____

Diagnosis _____

Date of Injury _____ Next MD. Appt._____

☐ EVALUATE & TREAT

Rx Frequency: _____ days/week for _____ weeks.

Precautions: _____

_____

☐ POOL THERAPY

- ☐ POOL EXERCISES
- ☐ GAIT TRAINING
- ☐ RANGE OF MOTION
- ☐ STRENGTH TRAINING
- ☐ FLOATING TRACTION
- ☐ OTHER:_____

_____

☐ LAND THERAPY

- ☐ EXERCISES
- ☐ SOFT TISSUE MOBILIZATION
- ☐ JOINT MOBILIZATION
- ☐ RANGE OF MOTION
- ☐ STRENGTH TRAINING
- ☐ GAIT TRAINING
- ☐ MODALITIES
- ☐ OTHER:_____

I verify that physical therapy is medically necessary for this patient, that rehabilitation services will be rendered while the patient is under my care, and that the established treatment plan will be reviewed every thirty days as the patient's condition requires.

MD Signature: _____ Date: _____

MD Name (print): _____ Phone: _____

CompletePT
3283 Motor Avenue
Los Angeles, CA 90034

310/845-9690
Fax: 310/845-9691

www.CompletePT.com
info@CompletePT.com

- Medicare and Private insurance accepted.
- Blue Cross, Blue Shield providers

Katey Eisenstein, DPT
Daniel Leib, DPT
Mallory Withiam, DPT
Stephanie Jun, DPT
Steven Silverio, DPT
Jessica Bufete, DPT
Maytal Shay, DPT