

# PHYSICAL THERAPY REFERRAL FORM



LOCATIONS:  
FORT WORTH  
ALED  
BURLESON  
WEATHERFORD  
P. 682-235-3816  
F. 817-887-2719

PATIENT NAME

PATIENT PHONE

DIAGNOSIS/ICD-10 (REQUIRED)

DOB

## PHYSICAL THERAPY TREATMENT ORDER:

- |  |   |
|--|---|
| <input type="checkbox"/> EVALUATE AND TREAT      | <input type="checkbox"/> PER THERAPIST DISCRETION |
| <input type="checkbox"/> MANUAL THERAPY          | <input type="checkbox"/> BIOFEEDBACK              |
| <input type="checkbox"/> THERAPEUTIC EXERCISE    | <input type="checkbox"/> HOME EXERCISE PROGRAM    |
| <input type="checkbox"/> FUNCTIONAL DRY NEEDLING |   |

SPECIAL INSTRUCTIONS/PRECAUTIONS: \_\_\_\_\_

## DIAGNOSIS/PROBLEMS (FOR FEMALE AND MALE PATIENTS)

- |   |  |
|---|--|
| <input type="checkbox"/> PELVIC & PERINEAL PAIN (R10.2) | <input type="checkbox"/> URINARY FREQUENCY (R35.0)           |
| <input type="checkbox"/> LOWER ABDOMINAL PAIN (R10.30)  | <input type="checkbox"/> URGE INCONTINENCE (N39.41)          |
| <input type="checkbox"/> CONSTIPATION (K59.00)          | <input type="checkbox"/> STRESS URINARY INCONTINENCE (N39.3) |
| <input type="checkbox"/> ANAL SPASM (K59.4)             | <input type="checkbox"/> INCOMPLETE DEFECACTION (R15.0)      |
| <input type="checkbox"/> FECAL INCONTINENCE (R15.9)     | <input type="checkbox"/> DIASTASIS (M62.0)                   |
| <input type="checkbox"/> FECAL URGENCY (R15.2)          | <input type="checkbox"/> VOIDING DYSFUNCTION (N39.9)         |
| <input type="checkbox"/> DYSPAREUNIA (N94.1)            | <input type="checkbox"/> STRAINING TO VOID (R39.16)          |
| <input type="checkbox"/> VAGINISMUS (N94.2)             | <input type="checkbox"/> PROLAPSE (N81.9)                    |
| <input type="checkbox"/> HIP PAIN (M25.559)             | <input type="checkbox"/> VULVODYNIA (N94.89)                 |
| <input type="checkbox"/> LOW BACK PAIN (M54.5)          | <input type="checkbox"/> PUBIC SYMPHYSIS PAIN (M25.559)      |
| <input type="checkbox"/> THORACIC PAIN (M54.6)          | <input type="checkbox"/> SI JOINT DYSFUNCTION (M53.3)        |
| <input type="checkbox"/> COCCYX PAIN (M53.3)            | <input type="checkbox"/> PELVIC FLOOR WEAKNESS (M62.5)       |

OTHER: \_\_\_\_\_

FREQUENCY:     1X/WEEK     2X/WEEK     3X/WEEK

DURATION:     6 WEEKS     12 WEEKS     PER THERAPIST DISCRETION

PHYSICIAN SIGNATURE

DATE OF REFERRAL

OFFICE PHONE

OFFICE FAX

PHYSICIAN NAME PRINTED

NPI NUMBER

TO SCHEDULE AN APPOINTMENT CALL: 682-235-3816  
OR BOOK ONLINE AT:  
WOERNERPHYSICALTHERAPY.COM