



physical therapy and massage

8030 NE 5 AVE, Miami FL 33138
(786)703-3908 Phone
(786)703-3936 Fax

administration@care360physicaltherapy.com Email
www.care360physicaltherapy.com

PATIENT INFORMATION

Patient's Name: _____ Diagnosis/Surgical Procedure: _____
Patient's Date of Birth: _____
Patient's Phone: _____ Doctor's Follow up Date: ____/____/____

PHYSICAL THERAPY SERVICES

- | | | |
|--|--|--|
| <input type="checkbox"/> EVALUATE AND TREAT | <input type="checkbox"/> Therapeutic Activities | <input type="checkbox"/> Work Conditioning (x3/wk) |
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Work Hardening (x5/wk) |
| <input type="checkbox"/> Mobilizations | <input type="checkbox"/> Neuromuscular Re-education | <input type="checkbox"/> FCE |
| <input type="checkbox"/> Balance Training | <input type="checkbox"/> Gait Training | |
| <input type="checkbox"/> Strengthening/Endurance | <input type="checkbox"/> Postural Exercises/Back School/RPG/Schroth | |
| <input type="checkbox"/> Stretching/ROM | <input type="checkbox"/> Manual therapy (deep tissue, trigger points, myofascial release, ART) | |
| <input type="checkbox"/> Modalities for Pain | <input type="checkbox"/> Massage therapy | |

GOALS

- | | | |
|---|--|--|
| <input type="checkbox"/> Reduce Symptoms | <input type="checkbox"/> Improve Strength | <input type="checkbox"/> Improve ROM/Flexibility |
| <input type="checkbox"/> Improve Function | <input type="checkbox"/> Improve Endurance | <input type="checkbox"/> Improve Gait/Weight Bearing |

SPECIAL INSTRUCTIONS / PRECAUTIONS / ADDITIONAL COMMENTS

FREQUENCY OF TREATMENT:

- At Therapist's Discretion _____ days a week for _____ weeks

PROVIDER NAME: _____

NPI: _____

Signature

Date

____/____/____

My Signature authorizes this treatment to be medically necessary
Please fax this referral slip to (786)703-3926 **THANK YOU!**