**Ortho and Lymph PT**

**Phone: 971-220-1209**

**Secure fax: 971-238-4130**

Please fax face sheet, H&P, OP notes and treatment notes with referral form to expedite insurance authorization and coordinate care.

## Physical Therapy Referral Form

**Patient Name**: ________________________________________ Patient DOB:___________

**Diagnoses/ ICD-10 codes:** ______________________________________

_____________________________________________________________

____ PT Evaluate and Treat

____ Therapeutic Exercise (strength, conditioning, endurance)

____ Evaluate for compression garments

____ Lymphedema-related wound care

Frequency and duration of: __________ x/ week x _____ weeks

I certify that these services are medically necessary.

Physician signature: ________________________________Date ___________