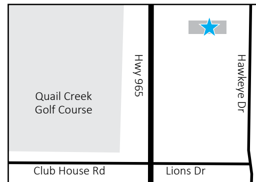
PHYSICAL THERAPY REFERRAL

7 Hawkeye Drive, Suite #105
North Liberty, IA 52317
Call/Text: 319-930-2868
Fax: 319-626-2669



Patient Name ________________________________ Date ______________

Diagnosis ____

Precautions/Comments ____

____

Frequency/Duration ____

☐ Evaluate and Treat	☐ Pain Science	☐ Modalities
☐ Strength/Endurance Exercises	☐ Dry Needling	☐ Heat ☐ Cold
☐ Range of Motion/Flexibility Exercises	☐ Strain Counterstrain	☐ Iontophoresis
☐ Balance/Coordination Exercises	☐ Graded Motor Imagery	☐ Ultrasound
☐ Stabilization/Motor Control Exercises	☐ Pain Adaptive	☐ Electrical Stimulation
☐ Dizziness/Vestibular Rehabilitation	☐ IASTM (Instrument Assisted Soft Tissue Mobilization)	

Next Physician Appt__________ Physician Signature ____________________________