Ph: 253-244-3465
Fax: 318.302.0140
ashley@scoliosisphysicaltherapy.com
www.scoliosisphysicaltherapy.com

Physical Therapy Referral

Patient Name: _____

DOB:_____

Patient's phone #: _____

Diagnosis: _____

Special Considerations: _____

_____

☐ EVALUATE and TREAT

☐ Other (please specify): _____

**Specialty Rehab Programs/Procedures:**

☐ Schroth scoliosis program ☐ Other _____

☐ Sportsmetrics prehab or return to sport

**Treatment Frequency:**

☐ Therapist discretion ☐ Other _____

Next MD Visit: _____

_____ _____

Physician signature Date

Physician phone # _____

Please fax this prescription to Scoliosis Physical Therapy @318-302-0140.

☐ Check if more referral pads are needed.