



WOERNER

PHYSICAL THERAPY

PHYSICAL THERAPY REFERRAL FORM

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P. 682-235-3816 F. 817-887-2719

PATIENT NAME

PATIENT PHONE

DIAGNOSIS/ICD-10 (REQUIRED)

DOB

PHYSICAL THERAPY TREATMENT ORDER:

- ☐ EVALUATE AND TREAT
- ☐ MANUAL THERAPY
- ☐ THERAPEUTIC EXERCISE
- ☐ FUNCTIONAL DRY NEEDLING

- ☐ PER THERAPIST DISCRETION
- ☐ BIOFEEDBACK
- ☐ HOME EXERCISE PROGRAM

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 DEFECATION (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"/> VULVADYNIA (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 ☐ 1X / WEEK ☐ 1X / WEEK  
DURATION: ☐ 6 WEEKS ☐ 12 WEEKS ☐ PER THERAPIST DISCRETION

PHYSICIAN SIGNATURE

DATE OF REFERRAL

OFFICE PHONE

OFFICE FAX

TO SCHEDULE AN APPOINTMENT CALL: 682-235-3816

OR BOOK ONLINE AT:

[WWW.WOERNERPHYSICALTHERAPY.COM](http://WWW.WOERNERPHYSICALTHERAPY.COM)