

# PHYSICAL THERAPY REFERRAL FORM



PELVIC FLOOR  
SPECIALISTS

P. 682-235-3816

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ALEDO  
FORT WORTH  
WEATHERFORD

PATIENT NAME \_\_\_\_\_ PATIENT PHONE \_\_\_\_\_

DIAGNOSIS/ICD-10 (REQUIRED) \_\_\_\_\_ DOB \_\_\_\_\_

## PHYSICAL THERAPY TREATMENT ORDER:

- |  |   |
|--|---|
| <input type="checkbox"/> EVALUATE AND TREAT      | <input type="checkbox"/> PER THERAPIST DISCRETION |
| <input type="checkbox"/> MANUAL THERAPY          | <input type="checkbox"/> BIOFEEDBACK              |
| <input type="checkbox"/> THERAPEUTIC EXERCISE    | <input type="checkbox"/> HOME EXERCISE PROGRAM    |
| <input type="checkbox"/> FUNCTIONAL DRY NEEDLING | <input type="checkbox"/> PLASTIC SURGERY RECOVERY |

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"/> VULVODYNIA (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     2X/WEEK     3X/WEEK

DURATION:     6 WEEKS     12 WEEKS     PER THERAPIST DISCRETION

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE OF REFERRAL \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_ OFFICE FAX \_\_\_\_\_

PHYSICIAN NAME PRINTED \_\_\_\_\_ NPI NUMBER \_\_\_\_\_