



Temple Physical Therapy

PATIENT REFERRAL FORM

Date _____

230 George St.
New Haven CT 06510
203-498-5980 Phone
203-498-5999 Fax

444 Foxon Rd.
East Haven CT 06512
203-468-4620 Phone
203-468-4621 Fax

680 S. Main St. Suite 102
Cheshire CT 06410
203-272-3120 Phone
203-272-3151 Fax

PATIENT INFORMATION

Patient's Name: _____

Patient's Phone: _____

Diagnosis/Surgical Procedure: _____

Precautions: _____

Physical Therapy Services

- | | |
|--|---|
| <input type="checkbox"/> Evaluate and Treat | <input type="checkbox"/> Modalities for symptom relief |
| <input type="checkbox"/> Manual therapy | <input type="checkbox"/> Iontophoresis |
| <input type="checkbox"/> Therapeutic Exercise | <input type="checkbox"/> Traction |
| <input type="checkbox"/> Neuromuscular Reeducation | <input type="checkbox"/> Orthotics |
| <input type="checkbox"/> Gait Training | <input type="checkbox"/> Special Instructions/Protocol Included |

Physical Therapy Services

- Work Hardening Program (5 x Week)
- Work Conditioning Program (3 x Week)
- Firefighter/Police Program (5 x week)

Physical Therapy Services

Frequency _____ x week for _____ weeks

Next MD Visit _____

Provider (print) _____

MD Telephone Number _____

Provider Signature _____

Date _____