

**Please Fax Patient Referral Slip to
559-438-4339 or 559.478.5715**

Patient's Name: _____ Date: _____

Diagnosis: _____

Date of Injury: _____ Date of Surgery: _____

Freq./Duration: _____

TREATMENT PROGRAM

Evaluate and treat as indicated by Diagnosis and Established Goals

MODALITIES

- _____ Hot Packs
- _____ Ice
- _____ Traction(Mechanical)
- _____ Paraffin Bath
- _____ Teris Trial
- _____ Unltrasonnd
- _____ Other _____

PROCEDURES

- _____ Massage
- _____ PROM
- _____ AROM
- _____ Neuromuscular Reeducation
- _____ Kinetic Activities
- _____ Soft Tissue Mobilization
- _____ Joint Mobilization
- _____ Manual Traction
- _____ Therapeutic Exercise
- _____ Other _____

SPECIFIC PROTOCOLS

- _____ ACL
- _____ PCL
- _____ MCLor LCL
- _____ Total Joint
- _____ Rotator Cuff
- _____ Decompression
- _____ Spinal Fusion
- _____ Laminectomy
- _____ Other _____

PATIENT EDUCATION

- _____ Back School
- _____ Home Exercise Program
- _____ Other _____

Physician's Signature

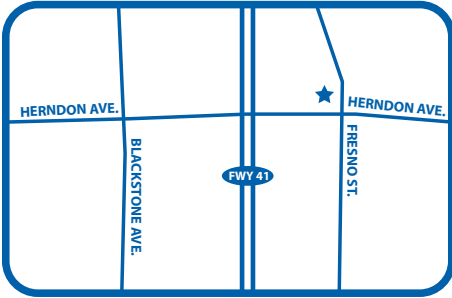
Date

Se habla Español



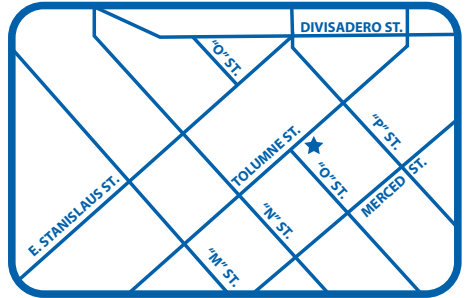
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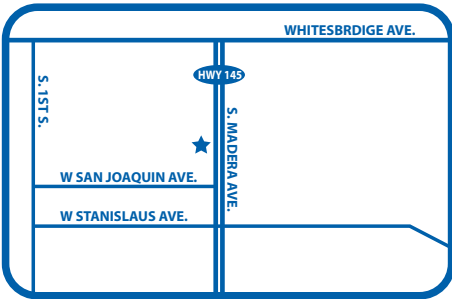
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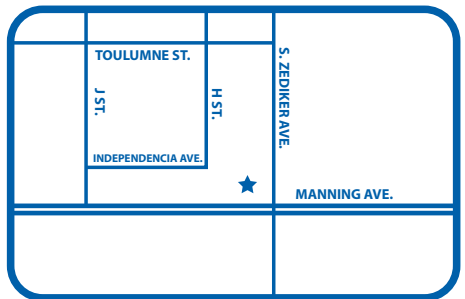
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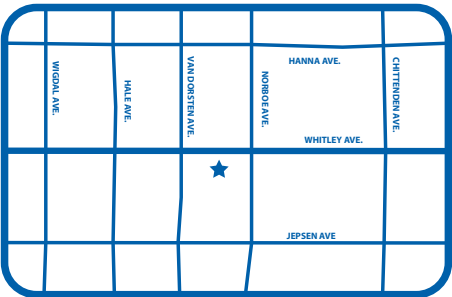
PARLIER

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