



SEDRO-WOOLLEY
Physical Therapy

PHYSICAL THERAPY REFERRAL

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Patient Name _____ Date _____

Diagnosis _____

Treatment Requested

- Evaluate and Treat
- ROM (PROM/AAROM/AROM) exercises
- Strengthening / Stabilization
- Home Exercise Program
- Work Conditioning
- Gait Training (% weightbearing _____)
- Modalities
- Manual Therapy / Joint Mobilization
- Proprioception / Balance Exercises
- Other _____

Frequency: _____ times per week for _____ weeks

Comments _____

Signature _____

Referring Physician

