ProFormance Physical Therapy

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- **Bob Bashaw, PT, SCS, OCS, ATC, CSCS**
- **Laura Nakata Vannucci, MPT**
- **Troy Vannucci, MPT**
- **Brandon Cridlebaugh, DPT**
- **Brian Scherr, MPT, CSCS**
- **Kelsie Slack, PTA**

PHYSICAL THERAPY REFERRAL

Patient: _____ Date: _____

Diagnosis: _____

Surgical Procedure: _____ Date of Surgery: _____

Precautions/contraindications: _____

❒ Therapist evaluate and determine use of procedures, modalities, and/or frequency of treatment.

❒ Evaluate and rehabilitate according to my orders:

_____

_____

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_____

Treatment Frequency: _____ per week for _____ weeks.

❒ Please send written progress reports.

❒ Please call/e-mail regarding this patient. e-mail address: _____

Patient to recheck with physician in _____ weeks.

Physician's signature: _____ M.D.