ProForm PT
physical therapy
personal training
performance training

Physical Therapy Referral

Patient Name: _____

Diagnosis: _____

- ❑ **Evaluate and Treat**
- ❑ Biomechanical Assessment
- ❑ Gait/Balance Training
- ❑ PROM/AAROM/AROM
- ❑ Splinting/Orthotic Fabrication
- ❑ Stretching/Mobilization
- ❑ Therapeutic Exercise
- ❑ Decompression Traction
- ❑ Posture/Body Mechanics Education
- ❑ Cold/Moist Heat
- ❑ Electrical Stimulation/TENS/IFC
- ❑ Ultrasound
- ❑ Home Exercise Program
- ❑ Healthy Lifestyle Assessment
- ❑ Weight Loss Program
- ❑ Medical Membership

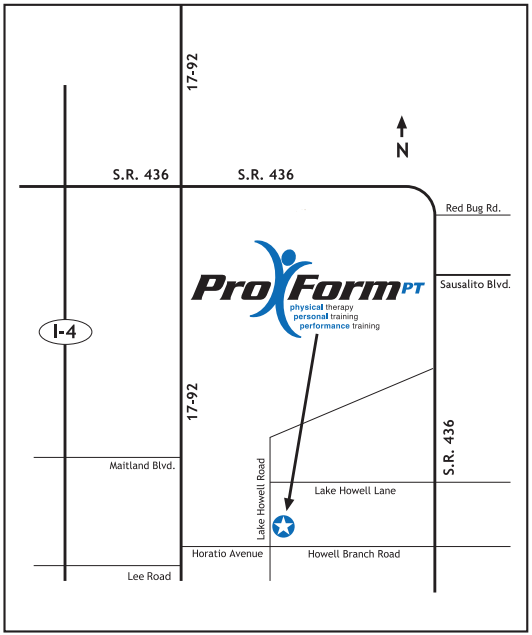
Comments: _____

_____

_____

_____

Signature Date



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