PHYSICAL THERAPY REFERRAL FORM

NAOMI JACOBS-EL, DPT, RYT, LMT

PHYSICAL THERAPY * YOGA THERAPY * MASSAGE THERAPY * WELLNESS CONSULTING

(256) 653-8280 njacobsel@yahoo.com www.NaomiJacobsEL.com

DATE: _____

PATIENT'S NAME: _____

PHONE: _____ **DOB:** _____

DIAGNOSIS: _____

PHYSICAL THERAPY: EVALUTATE AND TREAT: _____**X**_____ **weeks**

EVALUATIONS:

POSTURAL	ORTHOPEDIC	PEDIATRIC
GAIT TRAINING	TMJ	MASECTOMY
FALLS ASSESSMENT	ARTHRITIS	PRE/POST PARTUM
FUNCTIONAL	WHIPLASH	WOMEN's HEALTH
GENERAL NEURO	BACK/SPINE	MEN's HEALTH
STROKE	SPINAL STABILIZATION	INCONTINENCE
PARKINSON'S DISEASE	ACL/MCL	PAIN MANGEMENT
MULTIPLE SCLEROSIS	STATUS POST ARTHROSIS	DIABETES

EXERCISE:

RANGE OF MOTION	PRE/POST OPERATIVE
STRENGTHENING	EDUCATION
CARDIOVASCULAR FITNESS	OTHER_____

MODALITIES:

HEAT	IONTOPHORESIS
CRYOTHERAPY	JOINT MOBILIZATION
TENS	SOFT TISSUE MOBILIZATION
E-STIM	MYOFASCIAL RELEASE
ULTRASOUND	ORTHOTIC/PROSTEHETIC TRAINING
TRACTION	GAIT TRAINING
PARRAFIN	

SPECIAL INSTRUCTIONS/COMMENTS: _____

_____

_____

PRINT MD NAME: _____

MD SIGNATURE: _____

DATE: _____