11531 SE US Hwy 301
Belleview, FL 34420
Phone: (352) 307-0105
Fax: (352) 307-0124

TRI-COUNTY
REHAB SERVICES, LLC.

2500 Citrus Blvd.
Leesburg, FL 34748
Phone: (352) 728-6015
Fax: (352) 728-6012

OUTPATIENT PHYSICAL THERAPY REFERRAL FORM AND PLAN OF CARE

Patient Name: _____ Date of Onset: _____

Patient Phone #: _____

Diagnosis: _____

_____

Physician's Name: _____ Physician's Phone #: _____

Precautions/Contraindications: _____

_____

❒ **Evaluate and Treat**

Frequency: _____ times/week for _____ weeks

Affected Area

- ❒ Neck
- ❒ Mid Back
- ❒ Low Back (LB)
- ❒ Shoulder
- ❒ Elbow
- ❒ Wrist/Hand
- ❒ Pelvis
- ❒ Sacroiliac (SI)
- ❒ Hip
- ❒ Knee
- ❒ Ankle/Foot

Treatment Modalities

- ❒ Electrical Stimulation
- ❒ Ultrasound
- ❒ Hot Packs/Cold Packs
- ❒ Iontophoresis
- ❒ Mechanical Traction
- ❒ TENS
- ❒ Paraf n Bath
- ❒ Therapeutic Exercise
  - ❒ PREs
  - ❒ PROM/AROM/AAROM
  - ❒ Isokinetic
- ❒ Manual Therapy
- ❒ Muscle Re-education
- ❒ ADL Training
- ❒ Gait Training
- ❒ Balance Re-training

Programs

- ❒ Pain Management
- ❒ TMJ
- ❒ Vestibular Rehab
- ❒ Home Exercise Program
- ❒ Stroke Rehab
- ❒ Parkinson's
- ❒ Sensory Integration

❒ Other _____

_____

_____

_____

_____

I certify that I have examined this patient, and the above named patient requires therapy services for the problems identi ed above. I certify that the listed therapy services are medically necessary and that the treatment plan will be established, reviewed, and revised as needed every 30 days, or more frequently based on the patient's medical needs.

Physician's Signature: _____ Date: _____