TEXAS PREMIER PHYSICAL THERAPY

Patient Name: _____ Date: _____

Medical/Surgical Diagnosis: _____

ICD-10 Code: _____

Physician: _____

□ Evaluate & Treat □ Frequency/ Duration: _____

Modalities	Programs	Exercises
□ Hot Packs	□ Mckenzie Exercises	□ Active Rom
□ Cold Packs	□ Core Muscle Strengthening	□ Passive Rom
□ Ultrasound	□ Lumbar Stabilization	□ Stretching
□ Electrical Stimulation	□ ACL Post- Op Rehab	□ Strengthening
□ Massage	□ Foot and Ankle Program	□ Isometrics
	□ Shoulder Post-Op	□ PRE's
	□ Pre- Op	□ Mobilization
	□ THA □ TKA	□ Gait Training
	□ Other: _____	□ HEP
	□ HEP	□ Other: _____
	□ Other: _____	

Goals of Treatment

□ Decrease Pain/Edema
□ Increase Strength
□ Increase ROM/ Flexibility
□ Increase Endurance
□ Improve Functional Activities
□ Improve Gait, Weight Bearing Status _____
□ Progress Weight Bearing to _____
□ Other: _____

Physician Comments _____

_____

Physician Signature: _____ Date: _____

This referral certifies that physical therapy is medical necessary.

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