



**NO UP-FRONT FEES**

**– START TREATMENT IMMEDIATELY –  
NO PRE-APPROVAL FROM INSURANCE COMPANIES NEEDED**

Patient Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Date: \_\_\_\_\_

**Physiotherapy orders:**  Evaluate and treat per physiotherapist discretion

**Therapeutic Exercise**

- Strengthening/PRE's
- Lumbar/Core Strengthening/Stabilization
- Cervical Strengthening/Stabilization
- Lower Extremity Strengthening/Stretching
- Upper Extremity Strengthening/Stretching
- Home Exercise Program

**Modalities**

- Cold Laser
- Moist Heat/Ice
- Electrical Stimulation/TENS
- Ultrasound

**Manual Therapy**

- Soft Tissue Mobilization/Massage
- Joint Mobilization
- Trigger Point Treatment
- PROPRIO- Neuro Facilitation (PNF)

**Workers Compensation Services**

- Work Hardening/Conditioning Evaluation & Treatment
- Functional Capacity Evaluation
- On Site Job Assessment
- Pre-Work Screen

**Specialized Services & Group MSPs**

- Pre-op/Post-op Instruction and Treatment
- Chronic Pain Program
- Migraine/Headache Treatment
- Home Exercise Program
- Weight Management
- Personal Training
- Massage Therapy
- 5-Week Group MSP:
  - Low Back Pain
  - Knee Pain
  - Cardiac Rehab
  - Balance & Fall Prevention

Preferred Language:  English  Punjabi  
Additional Instructions/Special Considerations: \_\_\_\_\_

**Frequency and Duration:** \_\_\_\_\_ times a week for \_\_\_\_\_ weeks

Physician Name \_\_\_\_\_ Signature \_\_\_\_\_

Phone: \_\_\_\_\_

In making this referral, the physician certifies that this prescribed physiotherapy is a medical necessity.