Pro-Active
Physical Therapy

Physical Therapy Referral

www.svproactive.com **Ph : 408 720 1700** **Fax : 408 720 6900**
1208 E Arques Avenue, Suite 115, Sunnyvale, CA 94085

Patient Name : _____ Patient Ph # : _____

Diagnosis : _____ Date of Birth : _____

ICD-9 Code : _____

Evaluate & Treat :

Programs :

- ☐ Ankle/Foot Rehabilitation
- ☐ Knee Rehabilitation
- ☐ Hip Rehabilitation
- ☐ Shoulder Rehabilitation
- ☐ Elbow/Wrist Rehabilitation
- ☐ Spinal Rehabilitation
- ☐ Gait Training

Procedures / Modalities :

- ☐ Joint Mobilization
- ☐ Soft Tissue Mob/MFR
- ☐ ICE/Heat
- ☐ Ultrasound
- ☐ Electrical Stimulation

Procedures / Modalities :

- ☐ Therapeutic Exercises
- ☐ Phono/Iontophoresis
- ☐ Traction - Manual/Mech.
- ☐ TNS - Home

Comments : _____

_____

Frequency : ☐ Daily ☐ 3 x week ☐ 2 x week ☐ 1 x week Total # of weeks :_____

I certify/re-certify that out-patient physical therapy is necessary & that service will be furnished while the patient is under my care. I estimate that these service will be needed for approximately _____ weeks.

Physician's Signature : _____ **Date:** _____