Phone: 512-878-0351 | Fax: 512-878-0356
101 Uhland Rd Suite 115 | San Marcos, TX 78666
www.limitless-pt.com

Mon-Thu: 9-7 | Fri: 9-3
Sat: by request | Sun: closed

Physical Therapy Referral Form

Patient Information

Name: ______________________ DOB: __________ Date: __________
Contact Number: ______________________
Physician's Name: ______________________
Diagnosis: ____
Medical Precautions: ____
____

Physical Therapy Treatment / Modalities

- ☐ Physical Therapy Evaluation and Treatment
- ☐ Spinal Decompression
- ☐ Post Surgical Therapy
- ☐ Sports injury Assessment
- ☐ Therapeutic Exercises
- ☐ McKenzie Exercises
- ☐ Neuromuscular Re-Ed
- ☐ Posture/ Body Mechanic Education
- ☐ Manual Joint Mobilization
- ☐ Trigger Point Therapy
- ☐ Myofascial Release
- ☐ Electrical Stimulation(TENS)
- ☐ Ultrasound
- ☐ Kinesotaping
- ☐ Gait Analysis/Training
- ☐ Wheelchair/Mobility Assessment
- ☐ Functional Training

Specialty Services

- ☐ Dry Needling
- ☐ Post Amputation Therapy
- ☐ Neuro/Post Stroke Therapy
- ☐ Vestibular/ Balance Therapy
- ☐ Fall Prevention Therapy
- ☐ TMJ
- ☐ Pelvic Floor Therapy
- ☐ Men's Health
- ☐ Pre/Postnatal Back Therapy

Frequency & Duration

Frequency:	☐ Therapist Discretion	☐ 1 x Week	☐ 2 x Week	☐ 3 x Week	☐ 5 x Week
Duration:	☐ Therapist Discretion	☐ 4 Weeks	☐ 6 Weeks	☐ 8 Weeks	☐ 10 Weeks

I hereby certify these services as medically necessary for the patient's plan of care.

Physician's Signature: ______________________________ Date: ____ /____ /____