P·E·A·K
PHYSICAL THERAPY CENTER

Performance Enhancement & Kinetic Physical Therapy
2041 Newcastle Ave Cardiff, CA 92007
Tel. 760.230.5432 • Fax 760.655.4336
www.peakptc.com

Physical Therapy Referral

Date:

Name:

Diagnosis: ____

____

____

____

ICD-9:

DOB:

- O Evaluate and Treat
- O Eval Only
- O Strengthening
- O Range of Motion
- O Neuromuscular re-education
- O Balance/Coordination
- O Gait Training
- O Home Program
- O Manual Therapy
- O Modalities prn
- O Posture Training
- O Kinesiology Taping
- O Core Stabilization
- O Surgical protocol: ________________

Precautions: ____

____

____

Follow up visit with physician scheduled for: ______________________________

PT Frequency and Duration: __________ X per week for __________ weeks.

By signing this referral I state that treatments are medically necessary.

____

Referring Physician's Signature