



**PHYSICAL THERAPY REFERRAL & CONSULTATION**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Phone: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

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

Request:  PT Evaluate and Treat       Evaluation Only       Pre Rehab

Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

If you request selective intervention for this patient, indicate below:

- |   |  |  |
|---|--|--|
| <input type="radio"/> Gait Evaluation/Training                        | <input type="radio"/> Modalities               | <input type="radio"/> Therapeutic Exercise   |
| <input type="radio"/> Home Program                                    | <input type="radio"/> Plyometrics              | <input type="radio"/> TMJ*   |
| <input type="radio"/> Instrument Assisted<br>Soft Tissue Mobilization | <input type="radio"/> Range of Motion          | <input type="radio"/> Trigger Point Dry Needling   |
| <input type="radio"/> Manual Therapy                                  | <input type="radio"/> Soft Tissue Mobilization | <input type="radio"/> Vestibular/Balance*<br>(BPPV, Parkinson's, Falls,<br>Unsteadiness, Stroke, MS) |
| <input type="radio"/> Manual Traction                                 | <input type="radio"/> Spine PT Treatment       |  |

Specialty:

- |   |   |
|---|---|
| <input type="radio"/> Blood Flow Restriction*   | <input type="radio"/> Oncology PT Treatment                       |
| <input type="radio"/> Breast Cancer Treatment*  | <input type="radio"/> Pelvic Floor (Men & Women)*                 |
| <input type="radio"/> Falls Prevention  | <input type="radio"/> Persistent Pain                             |
| <input type="radio"/> FCE*  | <input type="radio"/> Return to Sport/Functional Testing*         |
| <input type="radio"/> Functional Capacity Evaluation (FCE)*                               | <input type="radio"/> Running/Sports Examination & Assessment*    |
| <input type="radio"/> Injury Prevention Program   | <input type="radio"/> Senior Exercises                            |
| <input type="radio"/> Lymphedema*   | <input type="radio"/> Strength Conditioning                       |
| <input type="radio"/> Metabolic Conditioning<br>(Hypertension/Dyslipidemia/Hyperglycemia) | <input type="radio"/> Wellness Evaluation & Exercise Prescription |
| <input type="radio"/> Orthopaedics  | <input type="radio"/> Workers' Compensation                       |
|   | <input type="radio"/> Work Conditioning                           |

Comments: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

I certify that the treatment is medically necessary and will be reviewed every 30 days.

*Referring Provider's Signature*

*Please Print Name*

*Date*

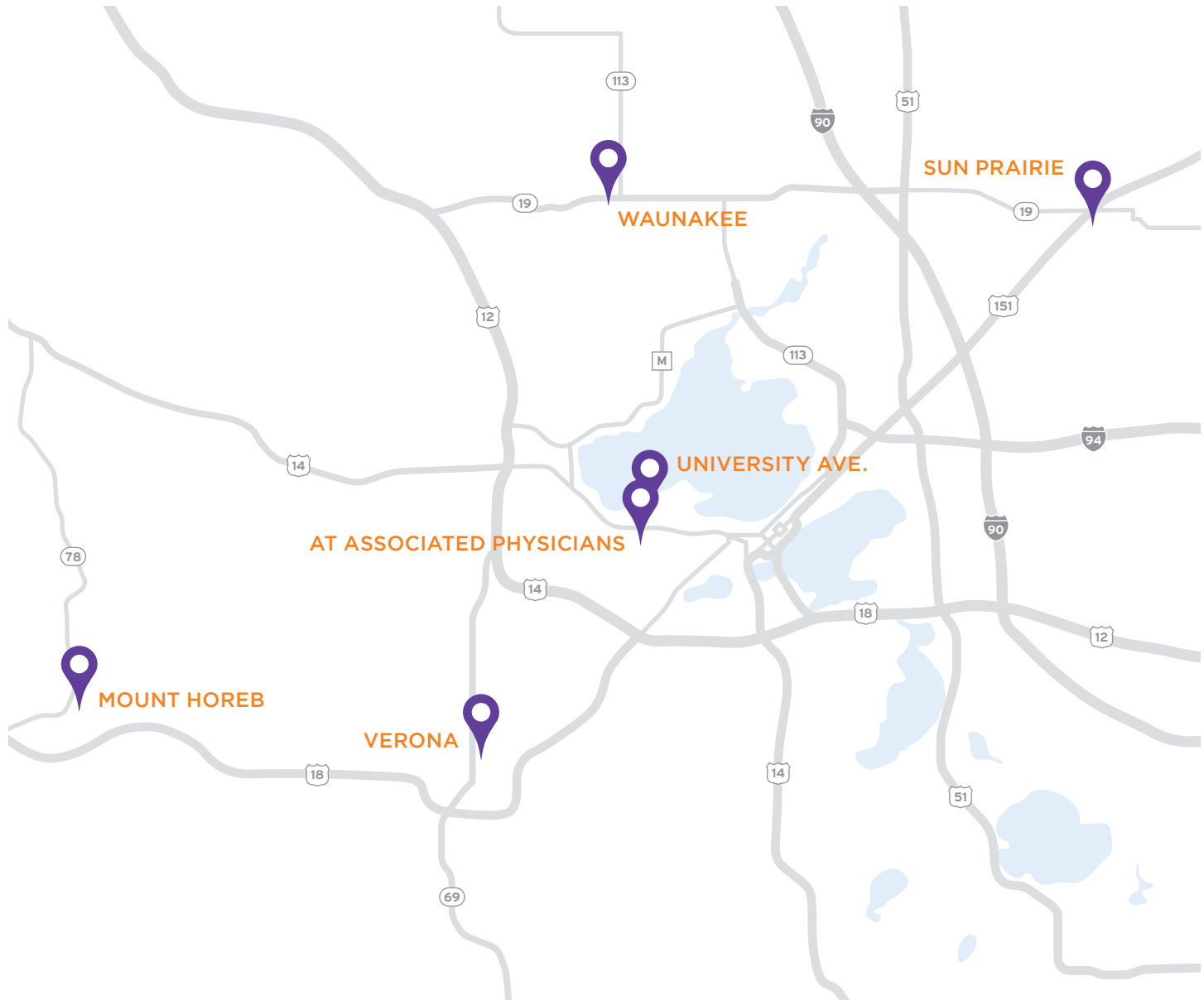
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\*Signifies programs not available at every location.



# Capitol Physical Therapy



### *At Associated Physicians*

4410 Regent Street  
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**p** 608.848.6628  
**f** 608.236.1981

### *University Avenue*

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### *Mount Horeb*

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Mt. Horeb, WI 53572  
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### *Sun Prairie*

1266 W. Main Street  
Sun Prairie, WI 53590  
**p** 608.318.1357  
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### *Verona*

416 E. Verona Avenue  
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### *Waunakee*

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[CapitolPhysicalTherapy.com](http://CapitolPhysicalTherapy.com)