EXPERT MANUAL THERAPY

SUPERIOR CARE, BETTER OUTCOMES

OFFICE ADDRESS
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Physical Therapy Referral

Patient Information

Last Name	First Name	Middle / Middle Initials

Phone	Date of Birth (MM/DD/YYYY)	Date

Diagnosis	Date of Onset	Phone

Other Contact & Phone #:

☐ **Face Sheet Attached** ☐ **Lastvisit/MedList Attached**

Diagnosis / Reason for Referral / Supplementary Notes

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Patient Treatment

☐ **Evaluate and Treat**

- ☐ Balance training
- ☐ Gait training/stairs
- ☐ Neuromuscular reeducation
- ☐ Biomechanics
- ☐ Fall prevention
- ☐ Therapeutic exercise
- ☐ Home program
- ☐ Manual Therapy
- ☐ Home safety assessement
- ☐ Functional training
- ☐ Transfer training

Physician Information

Physician Name	NPI #

Signature	Date

PLEASE FAX TO **512-277-7105** OR EMAIL TO **tsingh@expertmanualtherapy.com**