



5409 White Blossom Drive
Greensboro, NC 27410

T: 336-644-9661
F: 1-888-268-1042

E: info@cedarhillpt.com
www.cedarhillpt.com

REFERRAL FOR PHYSICAL THERAPY

Patient's name: _____

Diagnosis: _____ ICD9 Code: _____

- Evaluate and Treat
 - McKenzie Method
 - Dispense McKenzie rolls as indicated by PT evaluation
 - Motor Control (Stabilization) Training
 - Postural education/training
 - Ultrasound imaging for biofeedback
 - Manual Therapy
 - Aerobic, strength and flexibility training
 - McConnell patellofemoral program
 - Mechanical Traction
 - Cervical
 - Lumbar
 - Dispense home unit
- Falls Prevention Program
- TENS placement
- Exercise
- Work simulation
- Sports specific training
- ADL training

Other _____

Frequency/duration per physical therapy plan of care

-Or-

Frequency: 1 2 3 4 5 Days per week

Duration: 1 2 3 4 _____ Weeks

Treatment goals: Decrease pain Return to work Return to sports

Other: _____

Safety precautions: _____

Referred by (signature): _____ Date: ____ / ____ / ____

In signing this referral, I certify that the prescribed physical therapy is medically necessary.

To better assist the patient, please provide us with office/procedure notes and diagnostic reports related to the presenting condition.