



# majerus & company physical therapy

## PHYSICAL THERAPY REFERRAL FORM

phone: 360.253.4020 fax: 360.604.9293

16219 SE 12<sup>th</sup> St. #100 • Vancouver, WA 98683

[www.majeruspt.com](http://www.majeruspt.com)

Orthopedic Physical Therapy • Lymphedema • Compression Garments • Golf Rehab/Performance  
Car Accidents • Fractures • Total Joints • Sports Injuries • Women's Health • Pilates/V<sub>2</sub>Max Plus Reformer

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

### DIAGNOSIS

### ICD-9 CODE

### SPECIAL INSTRUCTIONS

### EVALUATE AND TREAT PROGRAMS

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Back/Neck Rehab      | <input type="checkbox"/> ACL Injury Prevention              | <input type="checkbox"/> Sports Screening/Concussion testing                                  |
| <input type="checkbox"/> Shoulder/Elbow Rehab | <input type="checkbox"/> Running/Gait Evaluation            | <input type="checkbox"/> Lymphedema/Other Swelling Reduction                                  |
| <input type="checkbox"/> Knee/Hip Rehab       | <input type="checkbox"/> Orthotics                          | <input type="checkbox"/> Compression Garments <input type="checkbox"/> Fit per therapist rec. |
| <input type="checkbox"/> Foot/Ankle Rehab     | <input type="checkbox"/> Pilates (STOTT PILATES® Certified) | <input type="checkbox"/> Strain Counterstrain   |
| <input type="checkbox"/> Pelvic Floor Rehab   | <input type="checkbox"/> Golf Assessment (TPI Certified)    | <input type="checkbox"/> Other _____  |

I certify that I have examined the above patient and that the therapies indicated are medically necessary. Services will be furnished by the above provider while the patient is under my care. The established Plan of Care (POC) will be reviewed as the patient's condition requires.

Physician Signature: \_\_\_\_\_ (printed surname) \_\_\_\_\_ Date \_\_\_\_\_

Please fax this form, patient demographics and pertinent chart note to **360.604.9293**. Your patient will be contacted within 24 hours.

**Thank you for your referral!**

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