



THE SMITH CLINIC
For Physical Therapy

8110 Cordova Road, Suite 107
Cordova, Tennessee 38016
(901) 756-1650 • Fax: (901) 756-1396

Physical Therapy Referral

Patient's Name: _____ Date: _____

Diagnosis: _____

Phone Number _____ DOB _____

Specific Treatment Requested

- | | |
|---|---|
| <input type="checkbox"/> Neck Program | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Shoulder Program | <input type="checkbox"/> Phonophoresis |
| <input type="checkbox"/> Back Program | <input type="checkbox"/> Iontophoresis |
| <input type="checkbox"/> Elbow Program | <input type="checkbox"/> Electrical Stimulation |
| <input type="checkbox"/> Hip Program | <input type="checkbox"/> TENS Setup |
| <input type="checkbox"/> Knee Program | <input type="checkbox"/> Hot / Cold Packs |
| <input type="checkbox"/> Ankle Program | <input type="checkbox"/> Bracing / Taping |
| <input type="checkbox"/> Foot Program | <input type="checkbox"/> Compression Therapy |
| <input type="checkbox"/> Work Conditioning Program | <input type="checkbox"/> Soft Tissue Mobilization |
| <input type="checkbox"/> Home Exercise Program | <input type="checkbox"/> Whirlpool |
| <input type="checkbox"/> ROM / Joint Mobilization | <input type="checkbox"/> Wound Care |
| <input type="checkbox"/> Cervical / Lumbar Traction | |

Comments / Special Instructions: _____

Evaluate and treat as indicated

Frequency: Daily 3x / Wk 2x / Wk 1x / Wk

Duration: _____ Weeks

This certifies Medical Necessity _____

Physician's Signature