175 Wilson Road, Suite 101 • PO Box 764 • Middlebury, VT 05753
(802) 388-3533 • Fax (802) 388-2334
AddisonWellnessPT.com

Patient Referral Form

Patient Name: _____ DOB: _____

Diagnosis/Date of Onset: _____

Contraindications/Precautions: _____

Treatment Prescription

____Evaluate and Treat

____Therapeutic Exercise

____Neuromuscular Re-education

____Aquatic Therapy

____Gait Training/Balance

____Modalities PRN

____Iontophoresis

____Continence Assessment with Biofeedback

____Other Please Specify: _____

Therapy: 1 2 3 4 5 times/week _____ Weeks.

Goals/Special Instructions: _____

____Patient will call to schedule ____Please call to schedule patient: Phone:_____

Physicians Name: _____

Physicians Signature: _____**Date:** _____