

# Rowe Physical Therapy & Associates

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 1400 Centre Street, Suite 104 ▪ Newton, MA 02459 ▪ Tel: 617-244-4462 ▪ Fax: 617-244-4435

## Referral for Physical or Occupational Therapy

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Physician Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Address:** \_\_\_\_\_

### TREATMENT PLAN

Evaluate & Treat (per practitioner's findings)		Soft Tissue Mobilization	
Therapeutic Exercise		Gait Training	Neurodevelopment Technique
Therapeutic Activities		Neuromuscular Re-Education	Sensory Integration
Myofascial Release		Postural/ Positional Education	Stretching
Manual Cervical Traction		Craniosacral Therapy	Strengthening
Visceral Manipulation		Relaxation Training	ADL Training
Lymph Drainage Therapy		Home Exercise Program	Balance Training
Joint Mobilization		Pt Education for Self-Care	Proprioceptive Training
			Other:

**Expected Frequency:** \_\_\_\_\_ per/week **Duration:** \_\_\_\_\_ weeks/months

**Short Term Goals:** \_\_\_\_\_ **Long Term Goals:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Rehabilitation Potential:**    \_\_\_ Excellent    \_\_\_ Good    \_\_\_ Fair    \_\_\_ Poor

**Precautions or Contraindications:** \_\_\_\_\_

**Physician's Comments:** \_\_\_\_\_  
 \_\_\_\_\_

**Physician's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician's NPI:** \_\_\_\_\_

**THIS REFERRAL FORM & PHYSICIAN'S SIGNATURE INDICATES  
 THE MEDICAL NECESSITY OF TREATMENT FOR SKILLED PT or OT.**

