COFFEE REGIONAL
MEDICAL CENTER

REFERRAL FOR PHYSICAL THERAPY SERVICES

100 Doctor's Drive, Suite 105
P.O. Box 1287
Douglas, GA 31534
Phone: (912) 383–5645 Fax: (912) 383–5677

Physician Offices–
For the most updated form please visit www.coffeeregional.org and print from the "For Our Physicians" link.

PATIENT NAME ____________________

DIAGNOSIS ____________________

PRECAUTIONS/SPECIAL INSTRUCTIONS ____________________

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________ **EVALUATE AND TREAT**

________ **EVALUATE ONLY**

MODALITIES

___ Hot Pack/ Cold Pack
___ Whirlpool
___ Electrical Stimulation
___ Ultrasound
___ Phonophoresis
___ Inontophoresis
___ Traction
___ Parrafin
___ Wound Irrigation
___ Fluidotherapy
___ Cold Compression
___ Other

EXERCISE PROGRAMS

___ Gait Traning
___ Balance/Vestibular Training
___ CVA Rehab
___ Home Exercise Program
___ Work Hardening
___ Work Conditioning
___ Biofeedback
___ Pediatric Services
___ Therapeutic Exercise
___ Other

PROCEDURES

___ Isokinetic Testing
___ Isokinetic Exercise
___ Joint Mobilization
___ Massage
___ Functional Capacity Eval
___ Impairment Rating Data
___ Splinting
___ Orthotic Training
___ Prosthetic Training
___ Pediatric Assessment
___ Body Mechanic Training
___ Fall Risk Screen
___ Other

FREQUENCY OF TREATMENT:

____ **AS NEEDED**

____ **TIMES PER WEEK FOR** ____ **WEEKS**

RETURNS TO PHYSICIAN: ____________________
(NEXT APPOINTMENT DATE)

____
PHYSICIAN'S SIGNATURE/ DATE