Physical Therapy Referral Form

www.AtlantaPT.com
Phone: 770.989.1405
Fax: 866.422.4791

Patient's Name:_____Date:_____

Patient's Phone Number:_____

Diagnosis: _____

Precautions//Weight Bearing Status: _____

ICD#: _____

Diagnostic Testing/ Surgery: _____

_____

_____

☐ Evaluate and Treat ☐ Contact before commencing treatment ☐ Other

Additional Comments: _____

_____

_____

_____

I hereby certify that the services indicated above are medically necessary for this patient's diagnosis.

_____
Physician Signature

Specialty Diagnoses Treated

Pelvic Health

- Pelvic floor dysfunction
- Pregnancy/Post-partum concerns
- Chronic Prostatitis
- Pelvic Pain
- Interstitial Cystitis
- Pudendal Neuralgia
- Bowel Dysfunction (Incontinence/Constipation)
- Urinary Incontinence
- Urinary Urgency/Frequency
- Painful sexual intercourse
- Coccygodynia
- **Pediatric** Bowel & Bladder Dysfunction
- Vulvodynia

Vestibular Therapy

- BPPV
- Vertigo
- Post- Concussion Syndrome
- Balance Impairments
- TMJ
- Headache

Women's Health

- Osteoporosis
- Breast cancer
- Post-mastectomy care

Orthopedics

- Athletic Injuries
- Chronic Pain
- Post-surgical rehabilitation
- Over-use injuries
- Return to Sport
- Joint pain
- Neck Pain
- Back Pain
- Pediatric/ Adolescent Sports Medicine
- Osteoarthritis
- Joint Hypermobility