MID STATE
Therapy Services

THERAPY REFERRAL

PATIENT: _____ **DATE:** _____

DIAGNOSIS: _____

EVALUATE & TREAT: PT / OT

FREQUENCY / DURATION: _____x week for _____ weeks

MOTION: Passive Active Active-assist Gentle Aggressive

WEIGHT BEARING: NWB WBAT Four Point Gait PWB TTWB

SPECIAL INSTRUCTIONS / PRECAUTIONS:

_____

PROTOCOLS:

- ☐ **Pre-operative Hip**
- ☐ **Total Hip Protocol**
- ☐ **ACL: Pre-op**
- ☐ **Ankle Sprain**
- ☐ **Elbow UCL Rehab**
- ☐ **Pre-operative Knee**
- ☐ **Total Knee Protocol**
- ☐ **ACL Protocol**
- ☐ **Scapula Instability**
- ☐ **Thumb CMC**
- ☐ **Shoulder Rehab**
- ☐ **Spine Rehab**
- ☐ **TFCC Repair**
- ☐ **Tendon Repair**
- ☐ **Tendon Transfer**

Physician: _____

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