action sports medicine
specialized training • injury treatment + prevention

Physical Therapy Referral

Patient's Name: _____ Date: _____

Dx: _____

Date of Surgery: _____

Duration of Treatment: □ 1 □ 2 □ 3 times a week for _____ weeks

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□ **Evaluation & Treatment**

□ Peripheral Joint Program
□ Back Care Program
□ Neck Care Program

□ Gait assessment + training

□ Protocol-specific request (please attach to referral)

□ Orthotics

□ Home Therapy

Therapeutic Activities

□ ROM
□ Strength Training
□ Flexibility Training
□ Balance Training
□ Proprioceptive Training
□ Endurance Training
□ Dynamic Stabilization
□ Sport-Specific Training Program
□ Home Exercise Program

□ Joint Mobilization
□ Soft/Deep Tissue Mobilization
□ Myofascial-Decompression (via cupping method)
□ Proprioceptive Neuromuscular Facilitation

Modalities

□ Ice
□ Heat
□ Vasopneumatic+Cryo Compression [GameReady]
□ Ultrasound
□ Biofeedback
□ TENS
□ Interferential Current
□ Electrical Stimulation
□ Iontophoresis
□ Traction

Comments:

_____

_____

_____

Physician's Signature: _____ Date: _____

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