PHYSICAL THERAPY TRANSFORMED

SELUCA PROFESSIONAL CENTER
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Fax patient referral form to 425.658.4977

Please include relevant MD notes, relevant diagnostics and medication lists

Patient Name ______________________

Patient Date of Birth ______________________

Diagnosis ______________ ICD Code __________

Precautions ______________________

Physician ______________________

Next Follow-up ______________________

Frequency (# of visits per week) ______________

Duration (# of weeks) ______________

Signature ______________ Date __________

☐ need more referral pads?

- ☐ Evaluate and Treat
- ☐ Post-Operative Protocol
- ☐ Custom Orthotics
- ☐ Running/Sport Specific Rehabilitation
- ☐ Home Program
- ☐ Thoracic Ring Approach
- ☐ Performing Arts Rehabilitation
- ☐ Strength and Conditioning
- ☐ Manual Therapy
- ☐ Balance and Gait Training
- ☐ Modalities (Ultrasound, electric stimulation, ice, etc)
- ☐ Iontophoresis
- ☐ Posture/ Ergonomics Education
- ☐ Specific Goals or Additional Comments

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