VITAL CARE
REHABILITATION, LLC

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Date: _____

Name: _____ Phone: _____

Significant medical hx/ Precautions/ contraindications: _____

DX: _____ Surgical procedures: _____

Date of Follow-up Appt with MD: _____

**Physical Therapy**

- ☐ Eval & Treat per PT discretion
- ☐ Modalities as indicated
- ☐ Therapeutic ex
- ☐ Manual therapy: MFR, STM, joint mobs, cerv/lumb traction, PROM
- ☐ Balance/gait/transfer training
- ☐ Instruction in posture/ergonomics/body mechanics
- ☐ Anodyne/Neuropathy
- ☐ Other : _____

**Social Service**

- ☐ Evaluate

**Physicians' long term goals for patient**

- ☐ Improve ROM
- ☐ Improve strength
- ☐ Improve activity tolerance
- ☐ Improve gait/balance/transfers/fall risk
- ☐ Improve posture awareness
- ☐ Decrease swelling/edema
- ☐ Decrease pain
- ☐ Return to work
- ☐ Other

Recommended Frequency & Duration: _____

Signature: _____

Printed Name: _____ NPI #: _____


*thank you for the referral*

CORF: 60 Day CERT Period
FROM:_____ TO:_____
Office use only

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