

**PHYSICIAN REFERRAL**

PHYSICIAN REFERRAL FORM FOR PHYSICAL THERAPY

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PATIENT'S NAME \_\_\_\_\_

DIAGNOSIS \_\_\_\_\_

FREQ / DURATION OF RX \_\_\_\_\_

EVALUATE AND TREAT

- |   |   |
|---|---|
| <input type="checkbox"/> Amputee Rehab                                  | <input type="checkbox"/> Massage  |
| <input type="checkbox"/> Athletic Rehab                                 | <input type="checkbox"/> Medcostonlator   |
| <input type="checkbox"/> Back Care Education                            | <input type="checkbox"/> Moist Heat   |
| <input type="checkbox"/> Brace <input type="checkbox"/> Splint          | <input type="checkbox"/> Open Wound Care  |
| <input type="checkbox"/> Burn Care <input type="checkbox"/> Debridement | <input type="checkbox"/> Paraffin   |
| <input type="checkbox"/> Cryotherapy                                    | <input type="checkbox"/> Phonophoresis  |
| <input type="checkbox"/> Contrast Bath                                  | <input type="checkbox"/> Pre- <input type="checkbox"/> Postnatal Ex                             |
| <input type="checkbox"/> Diathermy                                      | <input type="checkbox"/> Spray/Stretch  |
| <input type="checkbox"/> Electrical Stim                                | <input type="checkbox"/> TENS   |
| <input type="checkbox"/> Exercise                                       | <input type="checkbox"/> Traction <input type="checkbox"/> Cerv <input type="checkbox"/> Pelvic |
| <input type="checkbox"/> Evaluation                                     | <input type="checkbox"/> Traction Home Unit   |
| <input type="checkbox"/> Gait Training                                  | <input type="checkbox"/> Ultrasound   |
| <input type="checkbox"/> Iontophoresis                                  | <input type="checkbox"/> <input type="checkbox"/> with Cortisone Cream                          |
| <input type="checkbox"/> Infrared – ANODYNE                             | <input type="checkbox"/> Whirlpool <input type="checkbox"/> Sterile                             |
| <input type="checkbox"/> Jobst Compression                              | <input type="checkbox"/> Other (Specify)  |
| <br>  |   |
| <input type="checkbox"/> Functional Capacity Evaluation                 | <input type="checkbox"/> Work Conditioning Program  |
| <input type="checkbox"/> Back School Education                          | <input type="checkbox"/> Balance Training   |

\_\_\_\_\_  
Rx

DATE: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature