KINETIX
ADVANCED PHYSICAL THERAPY, INC.
www.kinetixapt.com

Physical Therapy Referral

❑ 23501 Cinema Dr., Ste. 116, Valencia, CA 91355
661.288.0300 • Fax: 661.288.0388
❑ 44501 16th Street West, Ste. 107, Lancaster, CA 93534
661.974.7033 • Fax: 661.974.7022

Patient _____ Date _____

Diagnosis _____

Treatment / Orders _____

Frequency / Duration: _____ x/wk _____ wks

Precautions: _____

❑ **EVALUATE & TREAT**

❑ **THERAPEUTIC EXERCISE**

- ❑ Strengthening
- ❑ Stretching
- ❑ ROM
- ❑ Gentle
- ❑ Aggressive
- ❑ Progressive

❑ **PRE / POST OP PROGRAM**

MODALITIES

- ❑ Modalities As Indicated
- ❑ Light / Laser Therapy
- ❑ Heat / Ice
- ❑ TENS
- ❑ Electrical Stimulation
- ❑ Traction
- ❑ Iontophoresis
- ❑ Ultrasound
- ❑ Phonophoresis
- ❑ Paraffin
- ❑ Whirlpool

PROCEDURES

- ❑ Mobilization
- ❑ Massage
- ❑ Myofascial Release
- ❑ Taping: ❑ McConnell ❑ Kinesio
- ❑ Desensitization
- ❑ Scar Management
- ❑ Wound Care

PROGRAMS

- ❑ Spinal
  - ❑ Cervical
  - ❑ Lx / Core Stabilization
  - ❑ McKenzie Protocol
  - ❑ Pilates
  - ❑ Post Op Protocol
- ❑ Knee
  - ❑ Patellafemoral
  - ❑ Meniscus
  - ❑ ACL Protocol
  - ❑ Wt. Bearing Tolerance _____
  - ❑ Other _____
- ❑ Shoulder
- ❑ Foot / Ankle
- ❑ TMJ Rehab
- ❑ Vestibular Rehab
- ❑ Balance Training
- ❑ Aquatic Therapy
- ❑ Gait Training

MEDICAL EQUIPMENT

- ❑ Bracing
  - ❑ Knee
  - ❑ Ankle
  - ❑ Wrist
  - ❑ Other
- ❑ TENS
- ❑ Home Traction Unit
- ❑ Shoulder Pulley Unit
- ❑ Crutches / Walker / Cane
- ❑ Leukotape / McConnell Tape Kit
- ❑ Other _____

Physician's Signature _____

Physician's Name (Please Print) _____

I hereby certify these services as medically necessary for the patients plan of care

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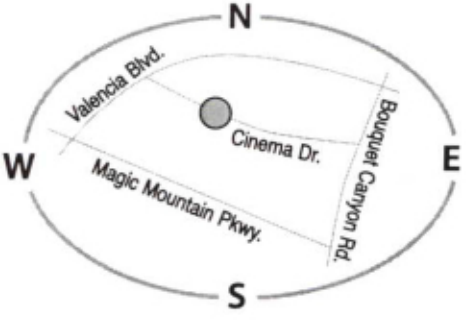

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