

PACIFIC BALANCE

& Rehabilitation Clinic

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Physical/Occupational Therapy Referral

Patient _____ phone _____

Diagnosis _____

Precautions/Remarks _____

PT/OT Evaluation and Treatment

Fall Prevention

Balance/Vestibular Retraining

Strength/Conditioning

Flexibility/Range of Motion

Joint or Soft Tissue Mobilization

Functional Rehabilitation

Pain Management

Core Stabilization

Modalities

Other _____

Frequency and Duration

Treatment _____ times a week for _____ weeks.

MD signature _____ **Date** _____

Prescription becomes effective on date of first scheduled appointment.

Patient must verify benefits and obtain authorization from Primary Care Physician if necessary.