PEAK PERFORMANCE
PHYSICAL THERAPY

Patient Name: _____

Patient Phone: _____

Diagnosis: _____

Precautions: _____

Date of Birth: _____

REQUEST FOR PHYSICAL THERAPY

Treatment

- ☐ Back/Neck Therapy
- ☐ Balance/ Coordination
- ☐ Evaluate & Treat
- ☐ Extremity _____
- ☐ Injury Prevention
- ☐ Occupational Injuries
- ☐ Post-Op Rehab
- ☐ Sports Performance
- ☐ Strength & Conditioning
- ☐ Work Readiness
- ☐ _____

Goals

- ☐ Improve Body Mechanics
- ☐ Improve ROM
- ☐ Imcrease Strength
- ☐ Relieve Pain
- ☐ Restore Function
- ☐ Teach Self-Management
- ☐ _____

Protocols

- ☐ THA
- ☐ TKA
- ☐ TSA
- ☐ RTSA
- ☐ ACL
- ☐ Attached
- ☐ _____

In making this referral, physician certifies that prescribed rehabilitation is medically necessary.

Physician Signature: _____

Physician Name: _____

Physician Phone: _____

Date: _____

(REQUIRED BY MEDICARE)

PLEASE FAX REFERRAL FORM TO: 509.579.0000
MYPEAKPHYSICALTHERAPY.COM
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