TherapeuticAssociates
PHYSICAL THERAPY

ALBANY

Patient Name: _____

Patient Phone: _____

Diagnosis: _____

Date of Birth: _____ Follow-Up Date: _____

REQUEST FOR PHYSICAL THERAPY

❒ EVALUATE AND TREAT AS APPROPRIATE

Treatment Frequency *(days per week)*: _____

Treatment Duration *(# of weeks)*: _____

Precautions/Contraindications:

_____

_____

_____

Comments/Special Orders:

_____

_____

_____

SPECIALIZED PROGRAMS

- ❒ Acute Low Back Pain
- ❒ Astym® Soft Tissue Treatment
- ❒ Chronic Pain
- ❒ Dizziness & Balance
- ❒ Ergonomic Assessment
- ❒ Joint Mobilization
- ❒ Manual Therapy
- ❒ Post-Op Rehabilitation
- ❒ Postural Education
- ❒ Spine Rehabilitation
- ❒ Sport-Specific Rehabilitation
- ❒ TMJ & Headache Treatment
- ❒ Women's Health

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

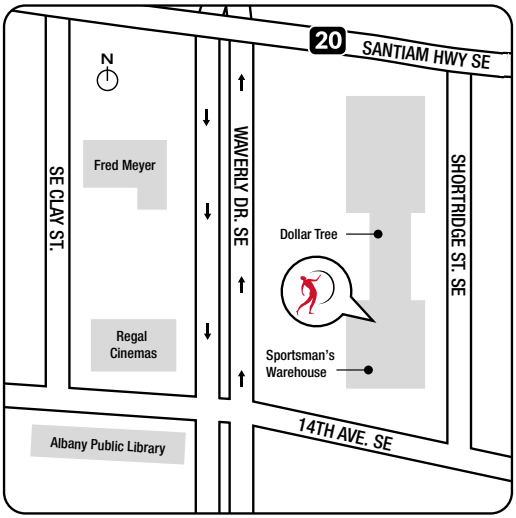
Physician Signature: _____

Physician Name: _____

Physician Phone: _____ **Date:** _____

(REQUIRED BY MEDICARE)

CLINIC LOCATION & PATIENT INSTRUCTIONS ON BACK



MID-VALLEY PHYSICAL THERAPY

Gregory Pick PT, MPT, OCS | *Clinic Director*

1325 Waverly Dr. SE | Albany, OR 97322

TEL: (541) 967-1224

FAX: (541) 967-2750

EMAIL: midvalley@taipt.com

Extended weekday hours - Please check our website for current clinic hours.

For additional locations outside the Albany area, visit:
www.therapeuticassociates.com/**Locations**

PATIENT INSTRUCTIONS

Please contact your preferred location to schedule your physical therapy visit. To prepare you for your upcoming visit with us, we encourage you to visit our New Patient webpage, where you can find information on the following:

- New patient forms
- What to expect & what to wear
- Insurance & billing
- Shared decision making

www.therapeuticassociates.com/Welcome