



Patient Name: _____

Patient Phone: _____

Diagnosis: _____

Date of Birth: _____ Follow-Up Visit: _____

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®
- MVA Rehabilitation
- Post-Operative Rehabilitation
- Sports Rehabilitation
- TMJ/TMD & Headache Treatment
- Vestibular & Balance
- Workers' Compensation Rehabilitation

Electronic Referrals – Need help connecting your system with ours?

We can help! Please send your inquiry to interoperability@taipt.com and a member of our IT Team will assist you.

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

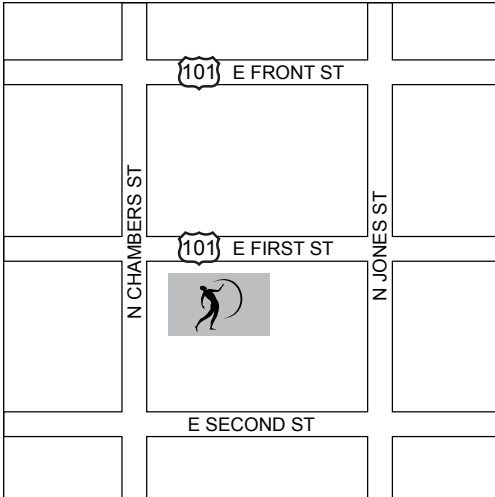
Provider Signature: _____

Provider Name: _____

Provider Phone: _____ Date: _____

(REQUIRED BY MEDICARE)

CLINIC LOCATIONS & PATIENT INSTRUCTIONS ON BACK



PORT ANGELES

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We also serve the Seattle Metro and Greater Tacoma areas.

For all clinic listings, please visit us online at

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:

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

www.therapeuticassociates.com/Welcome