SW WASHINGTON

TherapeuticAssociates
PHYSICAL THERAPY

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:

_____

_____

_____

PROGRAMS & SERVICES

- ❒ Advanced TMD Treatment
- ❒ Astym® Treatment
- ❒ Back and Neck Pain Care
- ❒ Injury Prevention
- ❒ Joint Mobilization
- ❒ Manual Therapy
- ❒ Massage/Soft Tissue Mobilization
- ❒ Patient Education
- ❒ Postural Restoration Techniques
- ❒ Running/Walking Analysis
- ❒ Strength & Conditioning
- ❒ Therapeutic Exercise
- ❒ Women's Health
- ❒ Worker's Comp Rehab

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

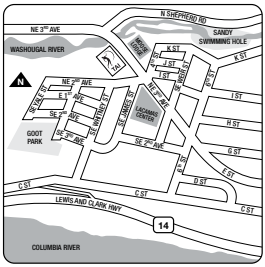
Provider Signature: _____

Provider Name: _____

Provider Phone: _____ **Date:** _____
(REQUIRED BY MEDICARE)

CLINIC LOCATIONS & PATIENT INSTRUCTIONS ON BACK

(REV 12/04/2023)



CAMAS

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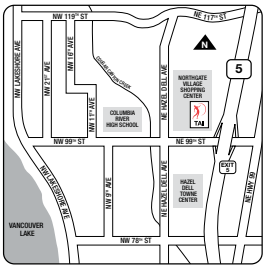

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We also serve the greater Portland Metro area. For location details, visit:
www.therapeuticassociates.com/**Portland**

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**