Private Therapy Services
Physical Therapy
815 Savannah Hwy Suite 101, Charleston, SC 29407
Phone: (843) 766-2121 Fax: (843) 766-8644

Physical Therapy Referral

Patient Name:_____

Diagnosis: _____

Precautions: _____

Surgical Procedures: _____

Frequency: _____**days per week for** _____**weeks.**
(This information is REQUIRED for MEDCARE patients)

Treatment Procedures (Please check one)

- ❑ **Evaluate and Treat**
- ❑ **Home Exercise Program**
- ❑ **Therapeutic Exercise**
- ❑ **Orthotic Training**
- ❑ **Spine Rehab**
- ❑ **Gait Analysis/Training**
- ❑ **Isokinetic Training**
- ❑ **Vestibular Rehab**
- ❑ **Ultrasound**
- ❑ **Phonophoresis**
- ❑ **Iontophoresis**
- ❑ **Paraffin**
- ❑ **Electrical Stimulation**
- ❑ **Traction**
- ❑ **Home TENS Unit**
- ❑ **Home Electrical Stimulation**
- ❑ **Work Conditioning Program**
- ❑ **Work Site Analysis**

Other Orders:

I certify the medical necessity of services furnished under this plan of care.

Physicians Signature: _____ **Date:**_____

Fax Number: _____
Phone Number: _____