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## PHYSICAL THERAPY REFERRAL

**Patient:** \_\_\_\_\_  
**Doctor:** \_\_\_\_\_  
**Diagnosis:** \_\_\_\_\_  
**Surgery:** \_\_\_\_\_  
**Weight Bearing Status:** \_\_\_\_\_  
**Work Restriction:** \_\_\_\_\_  
**Return to MD:** \_\_\_\_\_

### PLEASE INDICATE TREATMENT REQUEST

**Evaluate and Treat:** \_\_\_\_\_ **Modalities PRN:** \_\_\_\_\_

Knee Program	Shoulder Program	TKR/THR	Spine	Ankle/Foot	Elbow/Wrist/Hand
PROM		Ultrasound			SpineCare
AAROM		Iontophoresis			Pilates
AROM		Phonophoresis			Myofascial Release
Resistive Exercise		Electrotherapy/TENS			Woman.s Health
Gait and Balance		Aquatic Therapy		<b>Sport Specific</b> _____	
Postural Education		Traction		Plyometrics/ Power	
Core Stabilization		Manual Therapy/STM		Orthotic Evaluation	

**Additional Comments:**  
 \_\_\_\_\_  
 \_\_\_\_\_

**Frequency:** \_\_\_\_\_ **times/ week**      **Duration:** \_\_\_\_\_ **weeks**      **Daily**

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Thank you for this referral!*