

# GREEN OAKS PHYSICAL THERAPY REFERRAL

WWW.GREENOAKSPT.COM

PATIENT'S NAME

DATE

PATIENT'S TELEPHONE NUMBER

DOB

DIAGNOSIS

DOS

INSTRUCTIONS/PRECAUTIONS

Recommended Frequency: \_\_\_\_\_ times per week for \_\_\_\_\_ weeks.

**EVALUATE & TREAT**

**CONTINUE THERAPY**

## TREATMENT PROCEDURES

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Sports Medicine/Rehab            | <input type="checkbox"/> Tennis/Golfer's Elbow    | <input type="checkbox"/> Arthritis Program                  | <input type="checkbox"/> Pre-Employment Screen                   |
| <input type="checkbox"/> Manual Therapy                   | <input type="checkbox"/> Carpal Tunnel Syndrome   | <input type="checkbox"/> Heel Pain                          | <input type="checkbox"/> Work Conditioning                       |
| <input type="checkbox"/> Therapeutic Exercise             | <input type="checkbox"/> Total Joint Replacement  | <input type="checkbox"/> Plantar Fasciitis                  | <input type="checkbox"/> Home Program                            |
| <input type="checkbox"/> Knee/ACL Rehab                   | <input type="checkbox"/> McKenzie Spine Care      | <input type="checkbox"/> Post Surgical Foot/<br>Ankle Rehab | <input type="checkbox"/> Ultrasound                              |
| <input type="checkbox"/> Hip Bursitis/Tendinitis          | <input type="checkbox"/> Spinal Stabilization     | <input type="checkbox"/> Industrial Rehab                   | <input type="checkbox"/> Iontophoresis                           |
| <input type="checkbox"/> Rotator Cuff Rehab               | <input type="checkbox"/> Discogenic Pain/Sciatica | <input type="checkbox"/> FCE (at Fort Worth only)           | <input type="checkbox"/> Phonophoresis                           |
| <input type="checkbox"/> Shoulder Impingement<br>Syndrome | <input type="checkbox"/> Neck pain/UE Neuropathy  | <input type="checkbox"/> Ergonomic Analysis                 | <input type="checkbox"/> Aquatic Therapy<br>(at Fort Worth only) |
| <input type="checkbox"/> Frozen Shoulder                  | <input type="checkbox"/> Chronic Headache         |   |  |
|   | <input type="checkbox"/> Fall Risk Assessment     |   |  |

I hereby certify that the above services have been deemed medically necessary.

PHYSICIAN'S SIGNATURE

PHYSICIAN'S PRINTED NAME:

DATE

### ■ SOUTH ARLINGTON

**Kevin J. Dorf, MPT**  
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Now Offering Saturday Hours

### ■ NORTH ARLINGTON

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### ■ MANSFIELD

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### ■ MIDLOTHIAN

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### ■ WAXAHACHIE

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### ■ FORT WORTH

(Also offers Industrial Rehab,  
FCE's & Aquatic Therapy)  
**Andy Miles, MPT, Cert. MDT**  
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### ■ BENBROOK

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### ■ BURLESON

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### ■ LAKE WORTH

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### ■ BEDFORD

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### ■ IRVING/LAS COLINAS

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### ■ GRAND PRAIRIE

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### ■ CEDAR HILL

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### ■ DUNCANVILLE/DESOTO

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### ■ WHITE ROCK LAKE

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### ■ MESQUITE

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### COMING IN 2023

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Duncanville, and Cleburne**

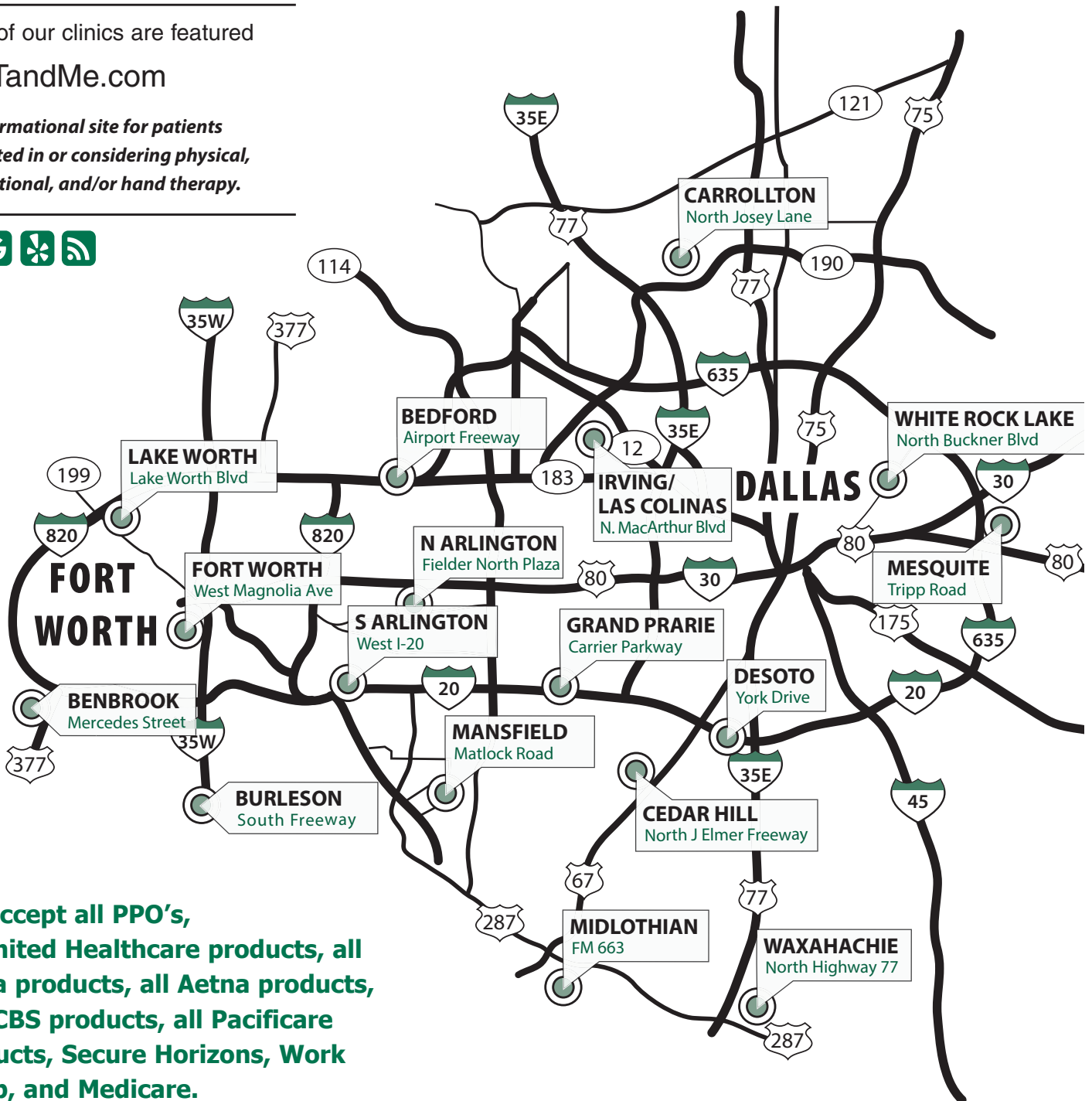
DO NOT EMAIL PRESCRIPTION. The electronic prescription form is provided for your convenience. With respect to responding to this form, please do not send the prescription via email. Please populate, print and sign a hardcopy that may be faxed, mailed or hand delivered to the clinic.



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An informational site for patients interested in or considering physical, occupational, and/or hand therapy.



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