

# 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

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### ■ FORT WORTH

(Also offers Industrial Rehab,  
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### COMING SOON

**Arlington (UTA), Richardson,  
Duncanville, and Cleburne**

# GREEN OAKS

## PHYSICAL THERAPY

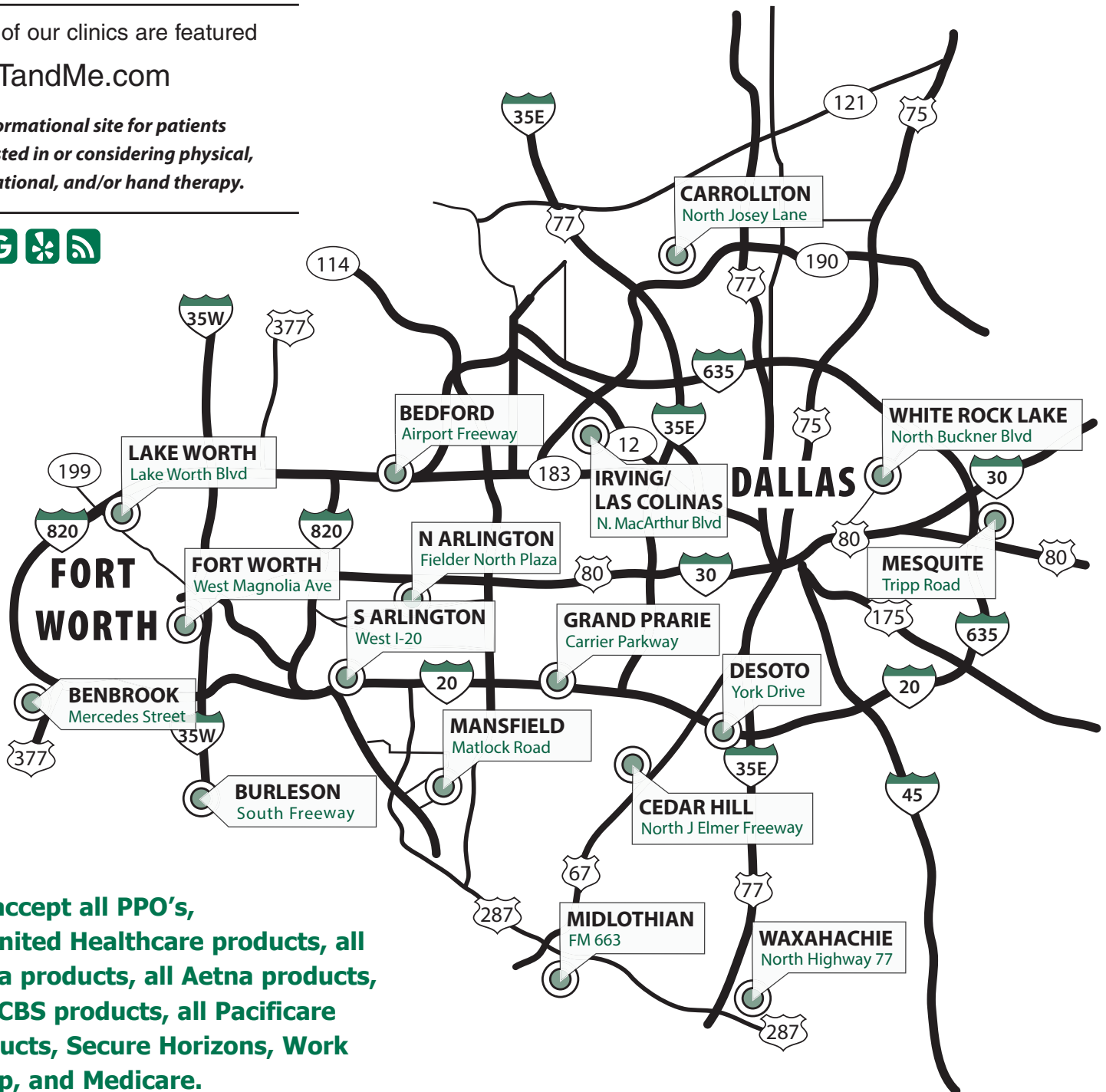
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