G4athlete
LIGHT YEARS

PHYSICAL THERAPY REFERRAL

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LIGHT YEARS

PHYSICAL THERAPY REFERRAL

PATIENT .....

DATE (Prescription becomes effective on date of first appointment.) .....

DIAGNOSIS ICD-9 ..... SURGERY (Date/Onset) .....

FREQUENCY & DURATION (required)

..... x per week for ..... weeks OR ..... visits

..... Physical Therapist evaluate and treat as appropriate

..... Treatment per protocol provided

PRECAUTIONS .....

FUNCTIONAL FITNESS

..... Functional Strength
..... Sport-Specific Training
..... Core Strength
..... Dynamic Flexibility

NUTRITION

..... Licensed Nutrition Counseling
..... Sports Nutrition
..... Weight Management
..... Consulting

SPORTS BIOMECHANICS

..... Biomechanical Assessment
..... Functional Testing
..... Custom Foot Orthotics
..... Sport Performance

MENTAL EDGE

..... Performance Assessment
..... Leadership Development
..... Individual Coaching
..... Consulting

MANUAL THERAPY

..... Skilled Mobilization
..... ROM .....
..... Licensed Massage Therapy
..... Activation, Release

OTHER SERVICES

..... Bracing .....
..... Taping .....
..... Supplies .....

Please update me on the patient's progress by: ..... written report ..... phone call

PHYSICIAN SIGNATURE .....
(required. signature of physician confirms medical necessity.)

PRINT NAME .....