sti
Physical Therapy and Rehab

Patient's Name

Date

Diagnosis

Referring Provider

Frequency per week:
○ 1x ○ 2x - 3x ○ Daily

Duration:
○ 1-2 weeks ○ 2-3 weeks ○ 4 weeks

ICD-9 / ICD-10

Date of Injury

Date of Surgery

Next Doctor's Appointment

Comments:

☐ Central Authorization Fax (602) 547-2806
☐ Yuma Central Authorization Fax 1 (866) 614-6074
☐ 14802 N. Del Webb Blvd., Sun City • 623-977-2775 P
☐ 17233 N. Holmes Blvd., Ste 1650 • 602-547-1836 P
☐ 9150 W. Indian School Rd., Suite #117 • 623-931-3838 P
☐ 444 W. Osborn, #303 • 602-279-8022 P
☐ 4840 E. Indian School Rd., #103 • 602-956-2850 P
☐ 1941 W. Guadalupe, Suite #108 • 480-491-3563 P
☐ 6309 E. Baywood • 480-759-5200 P
☐ 3970 W. 24th Street, Ste 108 • 928-783-0555 P
☐ 11361 S. Foothills Blvd., Ste 3 • 928-342-7234 P
☐ 5830 N. 19th Ave. • 602-841-0583 P

Physician's Signature
In making this referral physician certifies that presented rehabilitation is a medical necessity.

☐ **EVALUATE AND TREAT**

○ Hand ○ Back
○ Elbow ○ Hip
○ Shoulder ○ Knee
○ Neck ○ Foot/Ankle

☐ **EVALUATIONS**

○ ROM ○ AMA Impairment
○ Manual Muscle Testing ○ FCE
○ Sensibility ○ Medx
○ Strength (Grip/Pinch) ○ Other_____

☐ **THERAPEUTIC TREATMENT**

○ Active ROM ○ Posture Education
○ Passive ROM ○ Gait Training
○ Joint Mobilization ○ Closed Chain Exercises
○ Myofascial Release ○ Traction
○ Soft Tissue Mobilization ○ Wound Care
○ Work Conditioning ○ Topical Dressing
○ Strengthening ○ Therapeutic Exercise
○ Neuromuscular Re-ed ○ Medx
○ Lumbar Stabilization ○ Dry Needling
○ Other _____

☐ **MODALITIES**

○ Hot Packs ○ Interferential
○ Fluidotherapy ○ Iontophoresis
○ Ice Packs ○ Whirlpool
○ TENS/FES ○ Other_____
○ Ultrasound/Phonophoresis

☐ **ORTHOTICS**

○ Wrist Cock-up
○ Thumb Spica
- Hand Based
- Forearm Based

○ Volar Protection
○ Dorsal Protection

Static

○ Long Arm
Elbow _____
Wrist _____
MPs _____
IPs _____

Dynamic

○ Extension Assist
○ Flexion Assist