



Progress Physical Therapy & Wellness

11615 ANGUS RD STE 117A AUSTIN, TX 78759

Phone: 512-377-6750 Fax: 512-640-2013

Email: info@progress-physicaltherapy.com website: www.progress-physicaltherapy.com

Patient Information

Name: _____ Date of Birth: _____ Phone: _____

Provider Information

Name: _____ NPI #: _____

Phone: _____ Fax: _____

Reason for Referral / Provider Notes / Diagnosis/ICD-10 Code(s):

Precautions / Contraindications:

PT Evaluation & Treatment Orders (Check all that apply)

- Evaluate & Treat (Comprehensive PT Assessment)
- Gait, Balance, or Fall Prevention Training
- Therapeutic Exercise / Neuromuscular Re-education
- Pelvic Floor Therapy (Incontinence, Pelvic Pain, Pre/Postnatal, etc.)
- Orthopedic / Post-Operative Rehab (Procedure/Area: _____)
- Other: _____
- Pain Management / Manual Therapy / Soft Tissue Techniques
- Core Strengthening / Postural Training / Ergonomics
- Vestibular / BPPV Treatment

Frequency & Duration

1x/week 2x/week 3x/week Per Therapist Discretion Recommended Duration: ____ weeks

I hereby certify these services as medically necessary for the patient's plan of care.

Signature of Referring Provider: _____

Date: ____ / ____ / ____

Please fax completed form to (512) 640-2013 We will contact the patient directly to schedule an appointment.