Transcend PHYSICAL THERAPY

Orthopedics Sports Medicine Women's Health

To triumph over the negative or restrictive aspects of…

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Physical Therapy Referral

Patient Name: _____ **Date:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

☐ **Evaluation and treat per therapist discretion** ☐ **Evaluate and discuss treatment program** ☐ **Specific treatments**

Special Instructions (contraindications) / Diagnostic Tests Results: _____

_____

☐ **Equipment:** _____

Frequency/Duration: _____ **Date of Onset:** _____

Musculoskeletal Conditions

- ☐ Coccyx hypermobility
- ☐ Coccydynia
- ☐ Diastasis Recti
- ☐ Hip Joint/Pelvis/Thigh Pain
- ☐ Low back pain
- ☐ Pelvic/Hip Segmental Dysfunction
- ☐ SI dysfunction
- ☐ Sciatica
- ☐ Sacral Disorders
- ☐ Thoracic Pain
- ☐ Cervicalgia
- ☐ Shoulder: _____
- ☐ Knee: _____
- ☐ Ankle: _____
- ☐ Foot: _____

Pelvic Pain

- ☐ Dyspareunia, female
- ☐ Endometriosis
- ☐ Interstitial cystitis
- ☐ Painful scar
- ☐ Pelvic pain, female
- ☐ Vaginismus
- ☐ Vulvodynia/Vestibulitis

Genitourinary Disorders

- ☐ Cystocele
- ☐ Enterocele
- ☐ Rectocele
- ☐ Uterine prolapse
- ☐ Female stress incontinence
- ☐ Nocturnal Enuresis
- ☐ Urge Incontinence
- ☐ Urinary frequency
- ☐ Dysuria
- ☐ Retention of urine
- ☐ Hypertonicity/Overactive Bladder

Pelvic Muscle Dysfunctions

- ☐ Muscle incoordination
- ☐ Myalgia/Myositis
- ☐ Myalgia Syndrome/ Muscle Dysfunction
- ☐ Muscle spasm
- ☐ Muscle weakness

☐ **Post Surgical Status**

_____
_____
_____

☐ **Other:** _____

Physician Signature: _____ **Date:** _____

Physician Name Printed: _____

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