MINNESOTA THERAPY & BALANCE CENTER LLC
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REFERRAL FOR OUTPATIENT PHYSICAL THERAPY

Patient's Name: _____ **Date:** _____

Diagnosis: _____

_____

Precautions: _____

Please attach patient information including current insurance cards & last office notes.

_____ EVALUATE AND TREAT

INCLUDE THE FOLLOWING TREATMENTS:

_____ *THERAPEUTIC EXERCISE AND ACTIVITIES*
(ROM, strengthening, trunk stabilization, functional activity retraining)

_____ *NEUROMUSCULAR REEDUCATION*
(balance, proprioception, muscle reeducation, vestibular rehabilitation)

_____ *MANUAL TECHNIQUES*
(myofascial release, soft tissue mobilization, joint mobilization)

_____ *MODALITIES*
(ultrasound, electrical stimulation, mechanical decompression/ traction, iontophoresis)

_____ *GAIT TRAINING*
(improve gait pattern, instruction in use of assistive device)

_____ *HOME TENS UNIT OR TRACTION UNIT INSTRUCTION*

_____ *LSVT BIG® for Parkinson's Disease*

VESTIBULAR PROGRAM

_____ *VESTIBULAR REHABILITATION EVALUATE AND TREAT*

_____ COMPUTERIZED POSTURAL BALANCE, DYNAMIC VISUAL ACUITY, AND GAZE STABILIZATION ASSESSMENT AND TRAINING WITH NEUROCOM BALANCE MASTER PLATFORM AND INVISION SYSTEM

_____ DYNAVISION EYE-HAND COORDINATION ASSESSMENT & TRAINING, BENEFICIAL FOR CONCUSSION & HEAD INJURY REHABILITATION.

Other _____

Frequency and Duration: _____ Therapist's Discretion _____ x/ week for _____ weeks

Appointment Date: _____ Appointment Time: _____

Signature: _____