Physical Therapy, Inc.

☐ **COACHELLA**
50-225 Cesar Chavez St., Ste. 103
Coachella, CA 92236
760-698-8183 Phone • 760-698-8185 Fax

☐ **INDIO**
81-880 Dr. Carreon Blvd., Unit C101
Indio, CA 92201
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☐ **LA QUINTA**
79-440 Corporate Center Dr., Ste. 112
La Quinta, CA 92253
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☐ **RANCHO MIRAGE**
69-730 Highway 111., Ste. 100
Rancho Mirage, CA 92270
760-636-5207 Phone • 760-636-5209 Fax

☐ **PALM DESERT**
77-622 Country Club Dr., Ste. G
Palm Desert, CA 92211
760-345-3087 Phone • 760-345-6852 Fax

☐ **PALM SPRINGS**
1090 N. Palm Canyon Dr., Ste. D
Palm Springs, CA 92262
760-778-7150 Phone • 760-778-7180 Fax

Formerly ELITE Physical Therapy & Wellness

☐ **DESERT HOT SPRINGS**
13-313 Palm Dr., Ste. B
Desert Hot Springs, CA 92240
760-671-4760 Phone • 760-671-4798 Fax

www.allstarphysicaltherapy.com

Central Scheduling: Ph. (951) 304-7273 • Fax (951) 304-2560

PHYSICAL THERAPY REFERRAL

Name: _____ Phone: _____

Dx/ICD-10: _____ Date: _____

Procedures (as indicated)

☐ Evaluate and Treat	☐ Vestibular / Balance Training	☐ Strength & Endurance
☐ Joint Mobilization	☐ Therapeutic Exercise	☐ Mechanical Traction
☐ Soft Tissue Mobilization	☐ Trunk Stabilization	☐ Ultrasound
☐ TMJ Program	☐ Home Exercise Program	☐ Iontophoresis
☐ Taping	☐ Home TENS Trial	☐ Electrical Stimulation
☐ Gait Training	☐ Pelvic Floor	☐ Other

Special Instructions / Restrictions:

_____

_____

Frequency / Duration: _____ times / week for _____ weeks

I certify _____ re-certify _____ that I have examined the patient and Physical Therapy is necessary. Services will be furnished while my patient is under my care. A plan is established, and will be reviewed every 30 days or more often, if the patient's condition requires. I estimate that these services will be needed about _____ (specify number of days, weeks, or months).

Physician's Signature: _____ **Date:** _____

Physician's Name (Printed): _____