Pelvic Floor Physical Therapy Referral

THERAPY PARTNERS of North Texas
PHYSICAL THERAPY & SPORTS MEDICINE

☐ **HERITAGE TRACE**
Pelvic Health Specialists Powered by Therapy Partners of North Texas
4364 Heritage Trace Pkwy., Suite 108
Tel: 817-973-7660 Fax: 817-768-5313

☐ **NORTH RICHLAND HILLS/ KELLER**
8700 N. Tarrant Pkwy., Suite 113
Tel: 817-498-8344 Fax: 817-498-8702

☐ **SOUTHLAKE**
731 E. Southlake Blvd., Suite 150
Tel: 817-442-8600 Fax: 817-442-8603

☐ **FRISCO** ***(Formerly Achieve PT&P)***
7548 Preston Rd., Suite 145
Tel: 972-712-9693 Fax: 972-712-9625

In Network with Most Commercial Insurance, Medicare and limited Medicaid

PATIENT'S NAME _____ DATE _____

PATIENT'S TELEPHONE NUMBER _____ DOB _____

Physical Therapy Order

☐ **Evaluate and Treat** ☐ **Continue Therapy**

***ICD10 Diagnosis:** _____

☐ Pelvic and perineal pain (R10.2)
☐ Low Back Pain (M54.50)
☐ Prolapse (N81.9)
☐ Constipation (K59.00)
☐ Pelvic Floor Weakness (M62.5)
☐ Left Hip Pain (M25.552)
☐ Urinary Frequency (R35.0)
☐ Straining To Void (R39.16)
☐ Stress Urinary/Urge Incontinence (N39.3)
☐ Right Hip Pain (M25.551)
☐ Post-Prostatectomy (Z90.79)
☐ Pubic Symphysis Pain (M25.559)
☐ Dyspareunia (N94.1)
☐ Vaginismus (N94.2)
☐ Endometriosis (N80)
☐ Diastasis Recti (M62.08)

Recommended Frequency: _____ times per week for _____ weeks. ☐ per therapists discretion

Special Considerations/Precautions:

☐ If pregnant, cleared for internal exam ☐ _____

I hereby certify that the above services have been deemed medically necessary.

PROVIDER'S SIGNATURE _____ PRINT NAME _____ DATE _____

PHONE NUMBER _____ FAX NUMBER _____

Scan for all locations

Please attach patient insurance information, demographics & last treatment note