ADVANCE PHYSICAL THERAPY
CERTIFIED POSTURAL RESTORATION CENTER
77 South Elliott Road, Chapel Hill, NC 27514 phone 919.932.7266 fax 919.932.7250

Referral Order for Physical Therapy

Patient Name _____ DOB _____

Patient Primary Phone _____ Alternate Phone _____

Primary Insurance _____ Secondary Insurance _____

Chief Complaint _____

Physical Therapy Services Requested

☐ Evaluate and Treat ☐ Resume Previous PT Plan of Care ☐ Continue PT per Plan of Care

Recommendations to Include

☐ **Postural Restoration** ☐ **Schroth Method for Scoliosis** ☐ **Vestibular Therapy**

☐ Pediatric Physical Therapy ☐ Manual Orthopaedic Therapy ☐ Orthotic Evaluation

☐ Balance / Gait Training ☐ CranioSacral Therapy ☐ Myofascial Release

☐ Other _____

Requested Frequency

☐ _____ visit(s) per week for _____ weeks ☐ _____ for _____ weeks

PLEASE NOTE – Post-Op referrals require Operative Report, Protocols, & Current Medications

Post-Op Outpatient Physical Therapy for _____

Outpatient PT to begin after the following date _____

Referring Provider Name _____ Provider NPI _____

Facility _____ Phone _____

Address _____ Fax _____

I certify that the Physical Therapy services above are medically necessary and approved by me.

Provider Signature _____ Signed Date _____

Certification Effective Date _____