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**

☐ Pediatric Physical Therapy   ☐ Manual Orthopaedic Therapy   ☐ Orthotic Evaluation

☐ Balance / Gait Training

☐ 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 ______________