Orthopedic Surgery Physical Therapy Referral

Date: [Insert Date]

Patient's Name: [Patient's Full Name]

Patient's Date of Birth: [DOB]

Patient's Address: [Patient's Address]

Insurance Information: [Insurance Details]

Referring Physician:

Name: Dr. [Your Name]

Practice Name: [Your Practice Name]

Contact Information: [Your Phone Number, Email]

Reason for Referral:

[Brief description of the patient's orthopedic condition and the need for physical therapy]

Patient History:

[Brief history relevant to the orthopedic issue]

Goals for Physical Therapy:

- [Goal 1]
- [Goal 2]
- [Goal 3]

Additional Information:

[Any additional notes or special instructions]

Signature:

Dr. [Your Name], [Your Credentials]