

Physical Therapy Referral

Date: [Insert Date]

To: [Physical Therapist's Name]
[Physical Therapy Clinic Name]
[Address]
[City, State, Zip Code]

From: [Referring Physician's Name]
[Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Email Address]

Patient Information:

Name: [Patient's Name]
Date of Birth: [Patient's DOB]
Phone Number: [Patient's Phone Number]
Insurance Information: [Insurance Details]

Diagnosis: Osteoarthritis of [specific joints involved]
Treatment Goals: Improvement of mobility, pain reduction, and strengthening.

Recommended Treatment:

I am referring [Patient's Name] for physical therapy to address the limitations caused by arthritis. I believe that physical therapy will help in enhancing mobility, relieving pain, and providing the patient with strategies for managing their condition.

Additional Notes:

[Any specific concerns or additional instructions for the therapist]

Thank you for your assistance in treating this patient. Please feel free to contact me if you have any questions.

Sincerely,
[Referring Physician's Name]
[Medical License Number]
[Signature]