Pinnacle Kidz

Pediatric Physical Therapy

Therapy Referral/Prescription Form

Patient Name _____ **DOB** ____/____/_____
Diagnosis _____
Date of Onset _____
Precautions (if any) _____

Treatment Program

□ Evaluate & Treat

□ Developmental Stimulation
□ Balance/Coordination Training
□ Caregiver Training/Education
□ Neuromuscular Re-education
□ ROM/Strengthening
□ Gait/Mobility Training
□ Home Exercise Program
□ Therapeutic Activities
□ Other/Specify _____

Special Instructions/Precautions _____
_____
_____
Frequency/Duration _____

Physician Signature _____ **Date** _____

Our office will obtain **INSURANCE AUTHORIZATION** *on behalf of your patient*

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