



Pondera
REHABILITATION & FITNESS

Patients Can Self Register at:
www.PonderaRehab.com
Fax (530) 746-0657

Physical / Occupational Therapy Referral Form

Patient Required Information

Name*: _____ DOB: _____ Date: _____
Phone Number*: _____
Email address*: _____ (* indicates required item for contacting and scheduling)
Diagnosis: _____
Comments/Precautions: _____

Treatment / Modalities

☐ **Evaluation and Treatment at Therapist's discretion**

Additional Techniques Requested:

- | | |
|--|---|
| <input type="checkbox"/> Therapeutic Exercises | <input type="checkbox"/> Electrical Stimulation |
| <input type="checkbox"/> Neuromuscular Re-Ed | <input type="checkbox"/> Thermal Ultrasound |
| <input type="checkbox"/> Manual Therapy Techniques | <input type="checkbox"/> Taping for function |
| <input type="checkbox"/> Gait Analysis/Training | <input type="checkbox"/> Blood flow restriction |
| <input type="checkbox"/> Rehabilitative Ultrasound Imaging | |

Specialty Programs

- | | |
|---|---|
| <input type="checkbox"/> Pelvic Health | <input type="checkbox"/> Functional Movement Screen /
Selective Functional Movement Assessment |
| <input type="checkbox"/> Abdominal Wall Rehabilitation | <input type="checkbox"/> Wheelchair/Mobility Assessment |
| <input type="checkbox"/> Neurological Rehabilitation | <input type="checkbox"/> Running Mechanics & Coaching Program |
| <input type="checkbox"/> Pre-Injury Concussion Baseline Testing | <input type="checkbox"/> Vestibular Rehabilitation |
| <input type="checkbox"/> Post-Injury Concussion Rehabilitation | |

Frequency & Duration

Frequency: ☐ **Therapist Discretion** ☐ 1 x Week ☐ 2 x Week ☐ 3 x Week
Duration: ☐ **Therapist Discretion** ☐ 4 Weeks ☐ 6 Weeks ☐ 8 Weeks ☐ 10 Weeks

I hereby certify these services as medically necessary for the patient's plan of care.

Provider's Signature: _____ Date: ____/____/____

Printed Name: _____ NPI: _____

Office Address: _____

Office Fax: _____