Pondera
REHABILITATION & FITNESS

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

3291 Swetzer Rd
Loomis, CA 95650

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:

☐ Therapeutic Exercises
☐ Neuromuscular Re-Ed
☐ Manual Therapy Techniques
☐ Gait Analysis/Training
☐ Rehabilitative Ultrasound Imaging
☐ Electrical Stimulation
☐ Thermal Ultrasound
☐ Taping for function
☐ Blood flow restriction

Specialty Programs

☐ Pelvic Health
☐ Abdominal Wall Rehabilitation
☐ Neurological Rehabilitation
☐ Pre-Injury Concussion Baseline Testing
☐ Post-Injury Concussion Rehabilitation
☐ Functional Movement Screen / Selective Functional Movement Assessment
☐ Wheelchair/Mobility Assessment
☐ Running Mechanics & Coaching Program
☐ Vestibular 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: _____