View Menu

# BARNES PHYSICAL THERAPY

Orthopedic Certified Specialist

***Physical Therapy Referral***

Date: _____ Diagnosis/Code: _____

Patient Name: _____ Pt. Phone: _____ DOB: _____

Precautions/Comments: _____ Freq. / Dur. _____x week for _____weeks

- ❒ Evaluate and Treat
- ❒ DDMT (Daily Dosed Motion Therapy)
  - ❒ Therapeutic Exercise ❒ Neck/Back School
  - ❒ Home Program
- ❒ Manual Therapy
  - ❒ Joint Mobilization / Manipulation
  - ❒ Myofascial Release ❒ Rhythmic Stabilization
- ❒ Neuro-Muscular Reeducation
- ❒ Gait Training
- ❒ Custom Orthotics (Plaster Cast)
- ❒ Bracing/Taping as needed
- ❒ Ultrasound/E-Stim/Combo
- ❒ Cervical/Lumbar Mechanical Traction
- ❒ Other: _____

_____ _____

Physician's Signature Office Phone

**PLEASE FAX PRESCRIPTION TO LOCATION OF CHOICE**


**Leon Springs**
24165 IH-10 West, Ste #202
San Antonio, TX 78257
Phone: 210.698.1919 • Fax: 210.698.6919

**Medical Center**
8401 Datapoint Dr. #401-A
San Antonio, TX 78229
Phone: 210.979.7500 • Fax: 210.979.7501