



COULTER

PHYSICAL THERAPY

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Crossett, AR 71635
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Referral Instructions

Name: _____ Date: _____

Diagnosis: _____

TESTING

____ NCV upper extremity Bil / R / L ____ Functional Capacity Eval
____ NCV lower extremity Bil / R / L ____ Other: _____

TREATMENT INSTRUCTIONS

____ Evaluate and Treat ____ Manual Massage ____ Fludiotherapy
____ Moist Heat / Ice Pack ____ Whirlpool ____ Traction
____ Ultrasound / EMS ____ Paraffin ____ Electrical Stim
____ Ultrasound ____ Phoresor ____ TENS Unit
____ Shortwave Diathermy ____ Other: _____

EXERCISE INSTRUCTIONS

____ ROM / Stretching ____ Williams Flexion ____ Posture
____ Strengthening ____ Back Extension ____ Work Hardening
____ Aquatic Therapy ____ Back Stabilization ____ Home Program
____ Other: _____

SPECIAL INSTRUCTIONS / PRECAUTIONS

Frequency _____ days/week Durations _____ weeks

Referral Signature: _____