



Medical Referral Form

Date: _____

Patient Name: _____ DOB: _____

Contact Information: _____

Dx: (IC D-9): _____

Physical/ Occupational Therapy Evaluation and Treatment

Identify treatment areas by checking the box:

*Therapeutic Activities:	ADLS (feeding, toilet training)
Functional Mobility	Proprioceptive neuromuscular facilitation
Strengthening	Home exercise program
Neuromuscular re-education	*Sensory Processing (social, attention and behavioral skills)
Balance and gait training	
Developmental delays	*Assessment & Orthotics training
Myofascial release	*Electrotherapies:
*Other: Orthopedics	Interferential current
	Electrical muscle stimulation

Recommended Frequency and Duration: _____ times per week for _____ weeks.

Precautions/Contraindications/Other: _____

Physician's Signature: _____

Date: _____ **Ph:** _____

Physical Therapy Comments: _____

Members American Physical Therapy Association and licensed in the state of California.

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