



Physical Therapy Referral for Pelvic Floor Rehab

OUTPATIENT REFERRAL
 Fax (254) 526-8604 or (512) 597-1411

HOME HEALTH REFERRAL
 Fax (254) 628-7905

PLEASE FAX PATIENT DEMOGRAPHICS, INCLUDING FRONT & BACK OF INSURANCE CARD

Patient's Name: _____

Patient's Phone Number: _____

CHECK MEDICAL DIAGNOSIS BELOW		<input type="checkbox"/> EVALUATE & TREAT AS INDICATED	
<input type="checkbox"/> Chronic Pain – General	(338.29)	<input type="checkbox"/> Unspecified Back	(724.5)
<input type="checkbox"/> Chronic Prostatitis	(601.1)	<input type="checkbox"/> Muscle Incoordination	(781.3)
<input type="checkbox"/> Constipation, Unspecified	(564.00)	<input type="checkbox"/> Myalgia & Myositis	(729.1)
<input type="checkbox"/> Cystocele – Lateral	(618.02)	<input type="checkbox"/> Muscle & Tissue Atrophy	(728.2)
<input type="checkbox"/> Cystocele	(618.01)	<input type="checkbox"/> Nocturnal Enuresis	(788.36)
<input type="checkbox"/> Damage to Pelvic Joints/Ligaments	(665.60)	<input type="checkbox"/> Overactive Bladder Syndrome	(625.9)
<input type="checkbox"/> Detrusor Instability	(? ? ?)	<input type="checkbox"/> Painful Episiotomy	(674.3)
<input type="checkbox"/> Detrusor Sphincter Dyssynergia	(596.55)	<input type="checkbox"/> Painful Scar	(709.2)
<input type="checkbox"/> Diastasis Recti	(728.84)	<input type="checkbox"/> Pelvic Pain – Female	(625.9)
<input type="checkbox"/> Dysfunctional Voiding	(596.59)	<input type="checkbox"/> Peripheral Nerve Injury – Pelvis	(956.9)
<input type="checkbox"/> Dyspareunia	(625.0)	<input type="checkbox"/> Peripheral Nerve Injury – Sciatic Nerve	(956.0)
<input type="checkbox"/> Erectile Dysfunction	(607.84)	<input type="checkbox"/> Rectocele	(618.04)
<input type="checkbox"/> Incomplete Bladder Emptying	(788.21)	<input type="checkbox"/> Sciatica	(724.3)
<input type="checkbox"/> Incontinence – Fecal	(787.6)	<input type="checkbox"/> Spasm of Muscle	(728.85)
<input type="checkbox"/> Incontinence – Female Stress	(625.6)	<input type="checkbox"/> Sprain / Strain of Pelvis	(848.5)
<input type="checkbox"/> Incontinence – Male Stress	(788.32)	<input type="checkbox"/> Unspecified Disorder of Muscle/Ligaments	(728.9)
<input type="checkbox"/> Incontinence – Mixed	(788.33)	<input type="checkbox"/> Urinary Frequency	(788.41)
<input type="checkbox"/> Incontinence – Urge	(788.31)	<input type="checkbox"/> Uterine Prolapse	(618.1)
<input type="checkbox"/> Interstitial Cystitis	(595.1)	<input type="checkbox"/> Vaginismus	(625.1)
<input type="checkbox"/> Levator Ani Syndrome	(564.6)	<input type="checkbox"/> Vulvodynia / Vestibulitis	(625.9)
<input type="checkbox"/> Low Back Pain (Lumbago)	(724.2)	<input type="checkbox"/> Other:	

Special Instructions/ Precautions: _____

Physician's Name Printed: _____ *Date:* _____

Physician's Signature: _____