

## Physical Therapy Referral for Pelvic Floor Rehab

OUTPATIENT CLINIC

HOME HEALTH

*Patient Name:* \_\_\_\_\_ *Patient's Phone Number:* \_\_\_\_\_

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

MEDICAL DIAGNOSIS		<input type="checkbox"/> EVALUATE & TREAT AS INDICATED	
<input type="checkbox"/> Cystocele, Lateral (618.02)		<input type="checkbox"/> Painful Episiotomy (674.3)	
<input type="checkbox"/> Cystocele, Midline (618.01)		<input type="checkbox"/> Painful Scar (709.2)	
<input type="checkbox"/> Damage to Pelvic Joints/Ligaments (665.6)		<input type="checkbox"/> Peripheral Nerve Injury, Pelvis (956.9)	
<input type="checkbox"/> Detrusor Sphincter Dyssynergia (596.55)		<input type="checkbox"/> Peripheral Nerve Injury, Sciatic Nerve (956.0)	
<input type="checkbox"/> Detrusor Instability (596.51)		<input type="checkbox"/> Rectocele (618.04)	
<input type="checkbox"/> Dyspareunia (625.0)		<input type="checkbox"/> Sciatica (724.3)	
<input type="checkbox"/> Fecal Incontinence (787.6)		<input type="checkbox"/> Spasm of Muscle (728.85)	
<input type="checkbox"/> Incomplete Bladder Emptying (788.21)		<input type="checkbox"/> Sprain / Strain of Pelvis (846.8)	
<input type="checkbox"/> Interstitial Cystitis (595.1)		<input type="checkbox"/> Stress Incontinence, Female (625.6)	
<input type="checkbox"/> Levator Ani Syndrome (564.6)		<input type="checkbox"/> Stress Incontinence, Male (788.32)	
<input type="checkbox"/> Low Back Pain (724.2)		<input type="checkbox"/> Unspecified Disorder of Muscle/Ligaments (728.9)	
<input type="checkbox"/> Mixed Incontinence (788.33)		<input type="checkbox"/> Urge Incontinence (788.31)	
<input type="checkbox"/> Muscle Incoordination (781.3)		<input type="checkbox"/> Urinary Frequency (788.41)	
<input type="checkbox"/> Muscle Pain (729.1)		<input type="checkbox"/> Uterine Prolapse (618.1)	
<input type="checkbox"/> Muscle & Tissue Atrophy (728.2)		<input type="checkbox"/> Vaginismus (625.1)	
<input type="checkbox"/> Overactive Bladder Syndrome (596.51)		<input type="checkbox"/> Vulvodynia / Vestibulitis (625.9)	
<input type="checkbox"/> Pain, Pelvic / Genital (625.9)		<input type="checkbox"/> Other:	

*Special Instructions/ Precautions:* \_\_\_\_\_

*Physician's Name Printed:* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Physician's Signature:* \_\_\_\_\_



5302 Janelle Drive, Killeen, TX 76549  
 Phone: (254) 699-3933 Fax: (254) 526-8604  
 jmitchell@integrityrehab.net www.integrityrehab.net