



Referral For Physical Therapy

Patient Name: \_\_\_\_\_

Phone: \_\_\_\_\_

DOB: \_\_\_\_\_

Diagnosis/ Treatment area: \_\_\_\_\_

L >/< R

- ☐ TMD   ☐ DJD   ☐ Joint/ Disc pathology   ☐ Capsulitis   ☐ Arthritis   ☐ Myalgia   ☐ ↓'d MIO  
☐ HA   ☐ EA   ☐ Cervical   ☐ Parafunction   ☐ Hx of Trauma   ☐ Hypermobility

Recommendations:

- ☐ Evaluate and Treat   ☐ ↑ MIO   ☐ ↑ Stability   ☐ Ultrasound   ☐ Iontophoresis   ☐ Dry Needling   ☐ ↓ Inflammation  
☐ ↓ Trigger points   ☐ Cervical/posture

Comments:

Dentist or Provider Information

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Dentist or Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_