

True Care Medical Therapy Center

Services Dedicated to Children and Disabled Adults

REFERRAL FORM

P.T. O.T.

Patient's Name: _____

Diagnosis: _____

Comments/Precautions: _____

GOALS

- Relieve Pain Increase Range of Motion Increase Strength
 Improve Functional Skills Decrease Edema Increase Endurance
 Improve Mobility/Ambulation
 Other _____

FREQUENCY

By Therapist's Treatment Plan OR _____ Times per Week for _____ Weeks

TREATMENTS

- Evaluate and Treat per Therapist's Discretion
- Modalities: E-Stim Ultrasound Cold Moist Heat
- Home Program and Education Visual Motor Integration
 Balance Recovery Developmental Delay
 Ambulation/Transfer Training Recover Activities of Daily Living
 Sensory Processing
 Wheelchair/Adaptive Equipment Evaluation or Training
 Other _____

More Referral Pads needed

Contact info, directions and map on back.
Our building is located behind Subway in Cook.



Medical Therapy Center

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