Name:

DOB:

Date:

NYU Medical Center
NYUHJD Orthopaedic Surgery

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PHYSICAL THERAPY REFERRAL

DIAGNOSIS: _____
PROCEDURE: _____
SURGERY DATE: _____

EVALUATE AND ESTABLISH TREATMENT PLAN: RANGE OF MOTION, MODALITIES, PRE's

__ WEIGHT BEARING AS TOLERATED
___ LIMITED WEIGHT BEARING AS TOLERATED IN EXTENSION FOR_____ WEEKS

___ FULL RANGE OF MOTION: _____ TO _____ FOR_____ WEEKS

___ GAIT EVALUATION AND TRAINING
___ FUNCTIONAL ACTIVITIES TRAINING
___ FLEXABILITY
___ CLOSED CHAIN STRENGTHINING
___ ECCENTRIC STRENGTHENING
___ HOME EXERCISE PROGRAM
___ Aerobic conditioning
___ VMO STRENGTHENING
___ Hydrotherapy if available
___ Posture evaluation and training
___ Core strengthening and body conditioning
___ PATELLOFEMORAL mobilization
___ Theraband Program

___ LOWER EXTREMITY PRE's: Quads, hamstring, calf, hip (AB/ADD) strengthening
___ UPPER EXTREMITY PRE's: Shoulder, arm, forearm
___ ROTATOR CUFF stretching and strengthening, periscapular mobilization and strengthening postural training, theraband program
___ PELVIC stabilization program, evaluate for posture and rotation
___ LUMBER spine rehab program
___ CERVICAL spine rehab program
SPECIAL INSTRUCTIONS:_____

DURATION: 2-3x per week for 8 weeks

SIGNATURE:_____ DATE_____