Mobility By Design

Mobile Outpatient Physical Therapy
Phone: 832-558-2271 Fax: 346-253-3838

Referral Request

Patient Name:_____ Date of Birth:_____

Patient / Caregiver Phone #: _____

Diagnosis / ICD-10: _____

Reason for Referral: _____

Date of Injury:_____ Date of Surgery:_____

Special Instructions:_____

☐ Physical Therapy Evaluate & Treat Frequency: _____ x per week for _____ weeks

Specific Requests

☐ Strengthening / Endurance Training
☐ Gait Training
☐ Fall Prevention
☐ Orthotic / Prosthetic
☐ Neurologic Rehab
☐ Orthopedic Rehab
☐ Medical Equipment Assessment/Training
☐ Wheelchair & other Mobility Assessments
☐ Balance / Coordination / Agility
☐ Transfer Training
☐ Home Safety Evaluation
☐ Home Exercise Program
☐ Posture Training
☐ Aquatic Therapy *
☐ Vestibular Rehab
☐ Other: _____

_____ _____ _____
Provider Signature Provider Name (Print) Date

Thank you for the referral
Please FAX to: 346-253-3838

*All services conveniently provided In Home. No home bound requirements.