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## Therapy Referral Form

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

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

Diagnosis: \_\_\_\_\_

Precautions: \_\_\_\_\_

### Services

Physical Therapy       Occupational Therapy

### Requested Treatments

- |   |   |
|---|---|
| <input type="checkbox"/> Evaluate and Treat                 | <input type="checkbox"/> Evaluate and Consult       |
| <input type="checkbox"/> Exercise (Strength/Endurance)      | <input type="checkbox"/> Splinting/Orthotics        |
| <input type="checkbox"/> ROM (Active/Passive)               | <input type="checkbox"/> Wound Care/Scar Management |
| <input type="checkbox"/> Gait Training                      | <input type="checkbox"/> Sensory Integration        |
| <input type="checkbox"/> Posture (Exercise/Education)       | <input type="checkbox"/> Cognitive Skills           |
| <input type="checkbox"/> Modalities (Ice, Heat, Ultrasound) | <input type="checkbox"/> Manual Therapy             |
| <input type="checkbox"/> Phonophoresis                      | <input type="checkbox"/> Massage                    |

Other Treatments: \_\_\_\_\_

Frequency: \_\_\_\_\_ Duration: \_\_\_\_\_

MD Signature: \_\_\_\_\_