AQUATIC PHYSICAL THERAPY REFERRAL

Active Chiropractic & Physical Therapy
101 S. Tracy Blvd. Tracy Ca 95376
Tel: (209) 830-8855; Fax: (209) 830-8837
Jim Miller, DC, DPT & Kay Miller, MPT

Name of Referring Doctor: _____

Address: _____

Phone number: _____ Fax number: _____

Name of patient: _____ Patient Diagnosis (ICD-10):_____

Patient Complaint: _____

_____

JUSTIFICATION OF SERVICES:

Currently the above named patient is unable to fully participate in land-based exercises as a result of one or more of the following reasons: **(Please Circle).**

- Increased pain
- Severe Weakness
- Weight-bearing restrictions
- Incorrect use of Assistive Device
- Decreased mobility due to Obesity
- Unique properties of water (buoyancy, hydrodynamics, hydrostatic pressure)

Frequency: ____x /wk x ____ wks or ____ # of visits

PHYSICIAN SIGNATURE: _____

(My signature indicates medical clearance and certifies the need for aquatic therapy)