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Revive Rehab

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info@reviverehabpt.com

Revive Rehab
PELVIC FLOOR PHYSICAL THERAPY

Patient Name: _____

Patient DOB: _____

Patient Phone: _____ **Patient E-mail:** _____

Patient Address: _____

Order for Physical Therapy Evaluation and Treatment

Dr. Jennifer L. Farrison, PT, DPT, OMT-C, Cert. DN, PCES

Dr. Allison R. Flowers, PT, DPT, OMT-C, Cert. DN, PCES, RYT

DIAGNOSIS/ICD-10

- ☐ **Pelvic Pain:** _____
- ☐ **Urinary:** _____
- ☐ **Bowel:** _____
- ☐ **Musculoskeletal:** _____
- ☐ **Other:** _____

POST-SURGICAL STATUS/DATE

- ☐ **Bladder Type:** _____
- ☐ **Hysterectomy:** _____
- ☐ **C-Section:** _____
- ☐ **Post Radiation/Chemotherapy:** _____
- ☐ **Other:** _____

TREATMENTS

- ☐ **Therapeutic Exercise**
- ☐ **Neuromuscular Re-Education**
- ☐ **Bladder/Bowel Retraining**
- ☐ **Manual Therapy**
- ☐ **Dry Needling**
- ☐ **Vaginal Dilator Instruction**
- ☐ **Biofeedback/sEMG**
- ☐ **Home Exercise Program Instruction**
- ☐ **Therapist Discretion**
- ☐ **Other:** _____

Precautions: _____

Special Instructions: _____

Physician Signature: _____ **Date:** _____

Physician Name (print): _____