

Date: _____

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Referral Form

◆ Patient's Name: _____ ◆ D.O.B. _____

◆ Diagnosis/Code: _____

◆ Precautions or Contraindications: _____

◆ Mode of Transport: _____

◆ Evaluate, assess and treat as indicated. (This will allow the physical therapist to develop and revise the treatment plan as warranted by the patient's condition.)

◆ Specific Program. (If you prefer a specific treatment program, please indicate.)

◆ Frequency:

◆ Duration:

_____ times per week.

_____ # times of weeks/or _____ # of sessions.

◆ Scheduled follow-up appointment with physician. Date: _____

◆ Functional Goals: _____

◆ Additional Comments: _____

◆ Physician's Signature

◆ Therapist's Signature