



# PHYSIOLOGIX PHYSICAL THERAPY

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## Physical Therapy Consultation / Treatment Request

**Patient Name:** \_\_\_\_\_

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

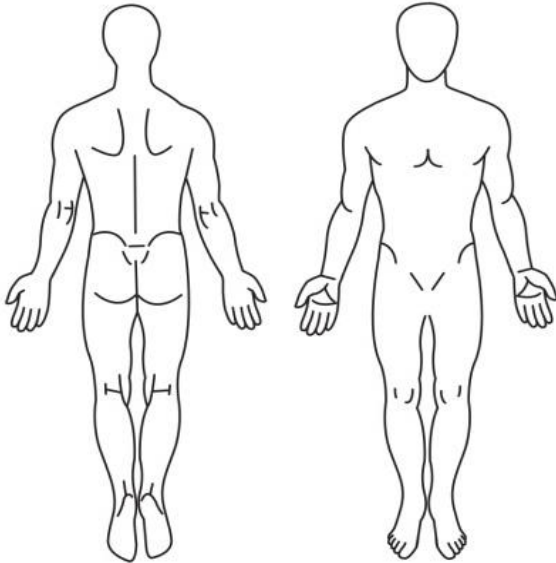
Please assess and treat as needed, or

**Assessment and Treatment of:**

**Services Requested:**

**Body Region:** Please circle or mark with an X

Acute     Chronic



MVA     WCB

- Shockwave Therapy
- Spinal Decompression / Traction
- Massage Therapy
- Radiculopathy Program
- Soft Tissue Program
- Exercise / Strength Training
- Stretching Program
- Trigger Point Program
- Neuropathy Program
- Fracture Program
- Other (specify below)

**Notes:** \_\_\_\_\_

Rapid referral to Psychiatry at therapist's discretion

Send report after initial assessment

**Referring Doctor:** \_\_\_\_\_

**Prac. ID:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

A report will be sent upon completion of treatment

[PhysioLogix.ca](http://PhysioLogix.ca)