

# GREEN OAKS PHYSICAL THERAPY REFERRAL

WWW.GREENOAKSPT.COM

PATIENT'S NAME

DATE

PATIENT'S TELEPHONE NUMBER

DOB

DIAGNOSIS

INSTRUCTIONS/PRECAUTIONS

Recommended Frequency: \_\_\_\_\_ times per week for \_\_\_\_\_ weeks.

**EVALUATE & TREAT**

**CONTINUE THERAPY**

## TREATMENT PROCEDURES

- |                                                           |                                                   |                                                                |                                                                  |
|-----------------------------------------------------------|---------------------------------------------------|----------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Sports Medicine/Rehab            | <input type="checkbox"/> Tennis/Golfer's Elbow    | <input type="checkbox"/> Arthritis Program                     | <input type="checkbox"/> Pre-Employment Screen                   |
| <input type="checkbox"/> Manual Therapy                   | <input type="checkbox"/> Carpal Tunnel Syndrome   | <input type="checkbox"/> Heel Pain                             | <input type="checkbox"/> Work Conditioning                       |
| <input type="checkbox"/> Therapeutic Exercise             | <input type="checkbox"/> Total Joint Replacement  | <input type="checkbox"/> Plantar Fasciitis                     | <input type="checkbox"/> Home Program                            |
| <input type="checkbox"/> Knee/ACL Rehab                   | <input type="checkbox"/> McKenzie Spine Care      | <input type="checkbox"/> Post Surgical Foot/<br>Ankle Rehab    | <input type="checkbox"/> Ultrasound                              |
| <input type="checkbox"/> Hip Bursitis/Tendinitis          | <input type="checkbox"/> Spinal Stabilization     | <input type="checkbox"/> Industrial Rehab                      | <input type="checkbox"/> Iontophoresis                           |
| <input type="checkbox"/> Rotator Cuff Rehab               | <input type="checkbox"/> Discogenic Pain/Sciatica | <input type="checkbox"/> FCE (at Fort Worth and<br>Plano only) | <input type="checkbox"/> Phonophoresis                           |
| <input type="checkbox"/> Shoulder Impingement<br>Syndrome | <input type="checkbox"/> Neck pain/UE Neuropathy  | <input type="checkbox"/> Ergonomic Analysis                    | <input type="checkbox"/> Aquatic Therapy<br>(at Fort Worth only) |
| <input type="checkbox"/> Frozen Shoulder                  | <input type="checkbox"/> Chronic Headache         |                                                                | <input type="checkbox"/> Concussion Program                      |
| <input type="checkbox"/> Fall Risk Assessment             |                                                   |                                                                |                                                                  |

I hereby certify that the above services have been deemed medically necessary.

PHYSICIAN'S SIGNATURE

DATE

### ■ SOUTH ARLINGTON

**Kevin J. Dorf, MPT**  
5833 West I-20  
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Now Offering Saturday Hours

### ■ NORTH ARLINGTON

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### ■ BEDFORD

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### ■ IRVING/LAS COLINAS

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Metro F: 866-639-0469

### ■ FORT WORTH

(Also offers Industrial Rehab,  
FCE's & Aquatic Therapy)  
**Andy Miles, MPT, Cert. MDT**  
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### ■ WAXAHACHIE

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### ■ WHITE ROCK LAKE

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### ■ MESQUITE (NEW!)

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### CLAIR PHYSICAL THERAPY

■ PLANO  
**Bob Clair, PT, CSMT**  
4621 W. Park Blvd, Suite 102  
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### FRISCO PHYSICAL THERAPY

■ FRISCO  
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# GREEN OAKS PHYSICAL THERAPY ORTHOPAEDIC SPINE & SPORTS

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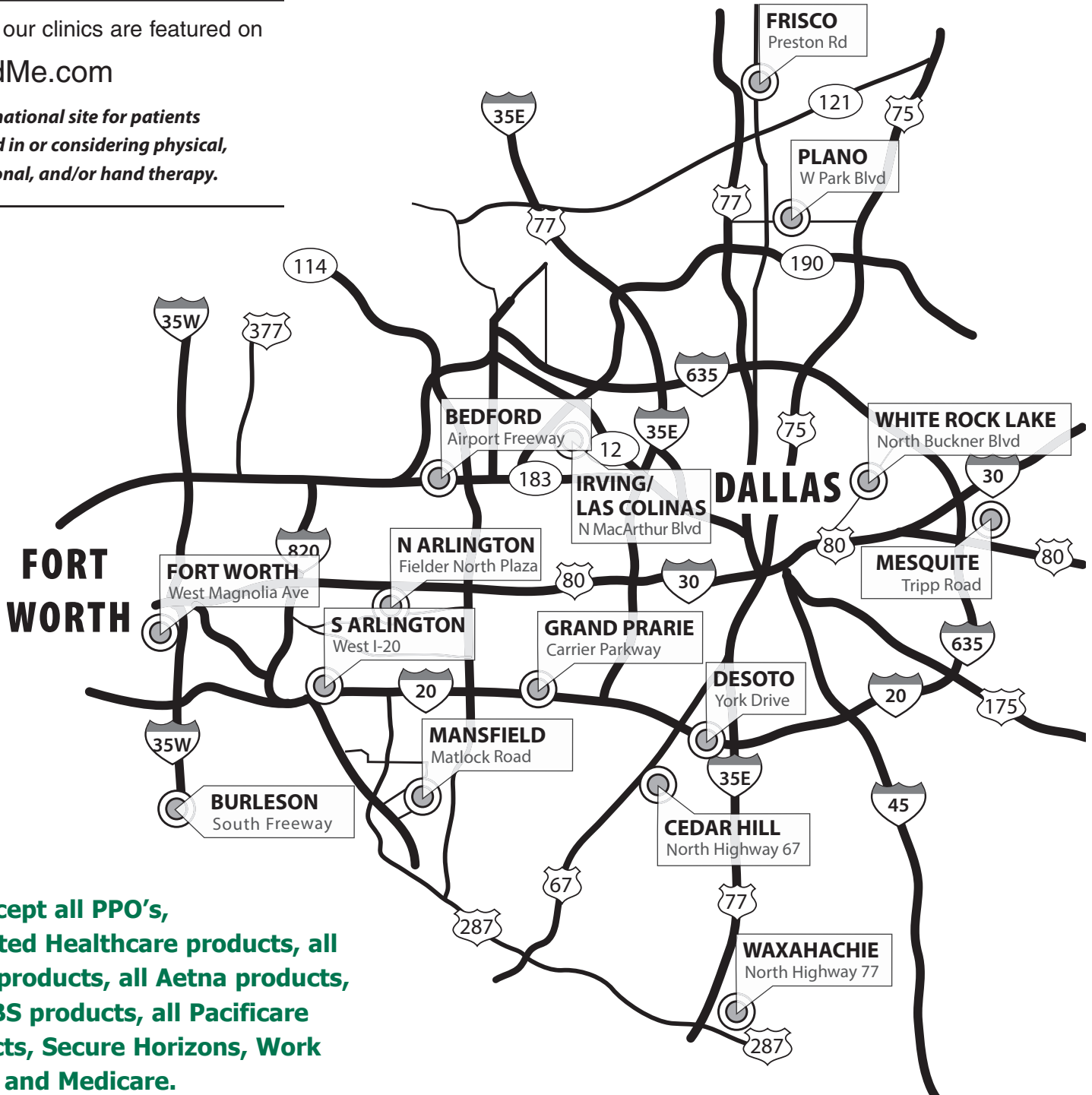


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