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Elite Sports Physical Therapy

**PEDIATRIC PHYSICAL THERAPY  
 PHYSICIAN REFERRAL**

**CHILD'S NAME** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**PHYSICAL THERAPY ORDERS (please check)**

<input type="checkbox"/> Pediatric physical therapy evaluation (motor/medical condition impacting development) & treatment	<input type="checkbox"/> Therapeutic Exercise (strengthening, increase active/passive range of motion for mobility)
<input type="checkbox"/> Orthotic evaluation, functional training, caregiver education	<input type="checkbox"/> Neuromuscular Reeducation (sitting/standing balance, coordination)
<input type="checkbox"/> Equipment evaluation (stander, mobility, adaptive bike, seating, home & community positioning)	<input type="checkbox"/> Gait Training (gait mechanics, stair training, assistive device training)
<b>FREQUENCY</b> (visits/week) _____ <b>DURATION</b> (#weeks) _____	<input type="checkbox"/> Other (specify)

**DIAGNOSES & ICD 9 CODES:** \_\_\_\_\_ **ONSET DATES**

\_\_\_\_\_  
 \_\_\_\_\_

**CLINICAL IMPRESSIONS & REASON FOR REFERRAL**

Please indicate chronic conditions and/or findings that led to the referral for physical therapy:

\_\_\_\_\_

**PRECAUTIONS AND CONTRAINDICATIONS**

Please indicate any medical precautions for this child, including allergies:

**PHYSICIAN, PLEASE NOTE: AFTER THE INITIAL VISITS, YOU WILL BE SENT PLAN OF CARE TO REVIEW AND SIGN. Thank you!**

Physician Signature \_\_\_\_\_

Print Name & License No. \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_