# Physiotherapy Referral Form

**Purpose:** This form is used by healthcare professionals to refer patients to a licensed physiotherapist for further evaluation and treatment based on medical findings and functional impairments.

## Patient Information

**Full Name:** {fullName}

**Date of Birth:** {dateOfBirth}

**Gender:** {gender}

**Phone Number:** {phoneNumber}

**Email Address:** {email}

**Address:** {address}

**Medical Record Number:** {medicalRecordNumber}

## Referring Physician

**Name:** {physicianName}

**Clinic/Hospital:** {clinic}

**Phone Number:** {physicianPhone}

**Email:** {physicianEmail}

**Date of Referral:** {referralDate}

## Diagnosis and Reason for Referral

**Primary Diagnosis:** {primaryDiagnosis}

**ICD Code:** {icdCode}

**Secondary Diagnoses:** {secondaryDiagnoses}

**Brief Summary of Patient Condition:**  
{conditionSummary}

**Reason for Referral:**  
{referralReason}

## Medical History

{medicalHistory}

## Current Medications

{#medications}

* **{medicationName}:** {dosage}, {frequency}

{/medications}

## Treatment Goals

{#treatmentGoals}

* {goal}

{/treatmentGoals}

## Recommended Physiotherapy Interventions

{#recommendedInterventions}

* {intervention}

{/recommendedInterventions}

{#hasPreviousPhysio}

**Previous Physiotherapy:**

*{previousPhysioDetails}*

{/hasPreviousPhysio}

{^hasPreviousPhysio}

**Previous Physiotherapy:**

*None reported*

{/hasPreviousPhysio}

## Functional Limitations

{#functionalLimitations}

* {limitation}

{/functionalLimitations}

## Additional Notes or Instructions

{additionalNotes}

## Supporting Documents

{#documentsAttached}

* {documentName}

{/documentsAttached}

## Authorization

**Signature of Referring Physician:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** {referralDate}

*This document is confidential and intended solely for the use of the individual or entity to whom it is addressed.*