Patient Name: ______________________________

Phone: ______________________________

Date of Birth: ______________________________

PELVIC HEALTH

PT/OT Referral

EVALUATION & TREATMENT

PRIMARY DIAGNOSIS

- ☐ Pain in joint; pelvic region/thigh
- ☐ Spasm of muscle
- ☐ Myalgia & Myositis, NOS
- ☐ Muscle/ligament/fascia disorder
- ☐ Muscle weakness
- ☐ Coccyx pain
- ☐ Back pain, NOS
- ☐ Sacrum
- ☐ Other:

SECONDARY DIAGNOSIS

- ☐ Abdominal pain/scar restrictions
- ☐ Other functional disorder of intestine
- ☐ Endometriosis
- ☐ Fecal incontinence
- ☐ Interstitial cystitis
- ☐ Vaginitis
- ☐ Urinary incontinence
- ☐ Vulvodynia
- ☐ Other:

This patient is referred to:

☐ **BRIDGEPORT**
5460 W. Rolling Hills Dr.
Bridgeport, MI 48722
Phone (989) 272-4500
Fax (989) 272-4501

☐ **CARO - M81**
1796 W. Caro Rd., Ste II
Caro, MI 48723
Phone (989) 672-5112
Fax (989) 673-3005

☐ **FRANKENMUTH**
406 W. Genesee St.
Ste B
Frankenmuth, MI 48734
Phone (989) 480-8872
Fax (989) 262-8514

☐ **MIDLAND**
2520 W. Wackerly St.
Midland, MI 48640
Phone (989) 423-1240
Fax (989) 423-1243

☐ **SAGINAW - STATE ST.**
4616 State St.
Saginaw, MI 48603
Phone (989) 355-1010
Fax (989) 355-1011

I certify that the therapy program is indicated and necessary and request these services be rendered to the above named patient.

X ______________________________ Date: ______________

Physician Signature

CORPORATE OFFICE: 804 N. Water St. Bay City, MI 48708 • (989) 450-3341