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Pelvic Wellness CENTER

Restoring function through physical therapy

Judy Abel PT
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PELVIC WELLNESS CENTER REFERRAL FORM

Date_____

Name_____ DOB_____ Phone_____

Diagnosis_____ ICD-9 Code_____

Surgery/Injury Date_____ Precautions/Contraindications_____

DIAGNOSIS

MUSCULOSKELATAL DYSFUNCTIONS

- ☐ Abdominal Wall Pain
- ☐ Back Pain
- ☐ Coccygodynia
- ☐ Diastasis Recti
- ☐ Hip Pain
- ☐ Lower Extremity Pain
- ☐ Obstetrical Low Back Pain
- ☐ Sacral Iliac Dysfunction
- ☐ Muscle Weakness
- ☐ Muscle Incoordination
- ☐ Other_____

GENITOURINARY DISORDERS/WEAKNESS

- ☐ Fecal/Anal Incontinence
- ☐ Pelvic Organ Prolapse:
  - ☐ Cystocele
  - ☐ Rectocele
  - ☐ Enterocele
  - ☐ Uterine Prolapse
- ☐ Stress Urinary Incontinence
- ☐ Urge Urinary Incontinence
- ☐ Urinary Frequency
- ☐ Voiding Dysfunction
- ☐ Other_____

GENITOURINARY PAIN

- ☐ Anismus
- ☐ Dyspareunia
- ☐ Levator Ani Syndrome
- ☐ Painful Episiotomy
- ☐ Pelvic Pain
- ☐ Proctalgia Fugax
- ☐ Vulvodynia
- ☐ Other_____

PEDIATRIC INCONTINENCE & PELVIC FLOOR DYSFUNCTION

- ☐ Enuresis
- ☐ Urge Incontinence
- ☐ Bedwetting
- ☐ Encopresis
- ☐ Dysfunctional Voiding
- ☐ Other_____

PHYSICAL THERAPY TREATMENT PLAN

☐ EVALUATE AND TREAT

- ☐ Therapeutic Exercise
- ☐ EMG Biofeedback
- ☐ Heat/Ice
- ☐ Electric Stimulation
- ☐ Behavior Modification (Bladder Training)
- ☐ Ultrasound
- ☐ Manual Therapy
- ☐ Other_____

NOTES

email judy@pelvicwellnesscenter.com

email shannon@pelvicwellnesscenter.com

Referring Provider_____

Provider Signature _____ Date _____