portlandpelvictherapy
specialized physical therapy
nari clemons, physical therapist

Physical Therapy Referral Form

Portland Pelvic Therapy

Specialized PT Nari Clemons,
Physical Therapist

560 NW 87th Terrace, Portland, OR 97229
Phone: (971)284-2062 Fax: 1-888-447-0339
www.portlandpelvictherapy.com

Patient Name _____ Patient Phone Number _____

Diagnosis/ICD _____ D.O.B. _____

Physical Therapy Treatment Order:

___Evaluate and Treat
___Manual Therapy
___Therapeutic Exercise
___**Per Therapist Discretion**
___Biofeedback
___Home Exercise Program

Specific Instructions/Precautions: _____

Diagnoses/Problems: (for female AND male patients)

____Pelvic Pain (R10.2)
____Abdominal Pain(R10.9)
____Hip Pain(M25.55)
____Lumbar/Flank Pain (M54.5)
____Sciatica (M54.3)
____Thoracic Pain (M54.6)
____Neuralgia (M79.2)
____Sacrococcygeal disorder (M 53.3)
____Pubic Symphysis Diastasis(026.73)
____Headache (784.0)
____Slow Transit Constipation (K59.01)
____Fecal Incontinence(R15.9)
____Painful Defecation (R30.0)
____Outlet Obstruction Constipation (K59.02)
____Incomplete Defecation (R15.0)
___Urge Incontinence(N39.41)
___Urinary Urgency(R39.15)
___Stress Incontinence (N39.3)
___Poor/Weak Stream (R39.12)
___Painful Urination(R30.0)
___Vulvadynia (N94.819)
___Perineal body tear/laceration(070.9)
___Abdominal adhesion/ restriction(K66.0)
___Prolapse (N81.1)
___Pelvic Muscle Wasting (N81.84)
___Irritable Bowel (K58)
___Rectus Diastasis(R14.0)
___Abdominal Bloating (R14.0)
___Dysmennorhea (N94.6)
___Scarring condition (L90.5)

Other: _____

Frequency: ___1x/week ___2x/week ___Per Therapist Discretion
Duration: ___6 weeks ___12 weeks ___Per Therapist Discretion

Physician Signature _____ Date of Referral _____ Office Phone _____ Office Fax _____

TO SCHEDULE, PLEASE CALL (971)284-2062 & FAX FORM TO (888)447-0339