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Tallahassee, FL 32308
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PELVIC HEALTH PHYSICAL THERAPY REFERRAL FORM

Patient NAME: ____________________________________ DOB: ___________________________

Patient PHONE No.: ________________________________

Diagnosis: ____ ICD 10: ___________________________

❖ Please include PATIENT FACESHEET AND MOST RECENT OFFICE VISIT NOTE with referral for therapy.

Reason for Referral:

Check all that apply

PHYSICAL THERAPY

- ❑ **Urinary Incontinence**
- ❑ **Urinary Urgency**
- ❑ **Fecal Incontinence**
- ❑ **Fecal Urgency**
- ❑ **Constipation**
- ❑ **Dyspareunia (Pain with Intercourse)**
- ❑ **Pelvic Organ Prolapse**
- ❑ **Post-Pelvic Radiation**
  - ❑ **Dilator Program Education**
  - ❑ **Truncal/Genital Lymphedema Management**
- ❑ **Pelvic Pain**
- ❑ **Coccyx Pain**
- ❑ **Scar/Adhesion Management**

NOTES:

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MD Signature

____
Print MD Name

____
TIME & DATE

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NPI