PROLETE

PHYSICAL THERAPY & SPORTS MEDICINE OF MILFORD

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PELVIC HEALTH REFERRAL

Patient Name: _____ D.O.B.:_____ Patient Phone No.: _____

Diagnosis: _____ Date: _____

- ❑ Manual Therapy
- ❑ Pre/Post Natal
- ❑ Strengthening
- ❑ Pelvic Pain
- ❑ Pelvic Organ Prolapse
- ❑ Pelvic Muscle Dysfunction
- ❑ Endometriosis
- ❑ Coccyx Disorders
- ❑ Prostatitis
- ❑ Stress Invontinence
- ❑ Urge Incontinence
- ❑ Interstitial Cystitis/Painful
- ❑ Bladder
- ❑ Post Prostate Surgery
- ❑ Sexual Dysfunction
- ❑ Fecal Incontinence
- ❑ Modalities
- ❑ Dry Needling
- ❑ Biofeedback

Precautions or Special Instructions:

_____

_____

_____

❑ Evaluate & Rx

Frequency _____

Duration _____

Doctor's Signature: _____

Print Doctor's Name: _____