FRANKLIN
REHABILITATION
Where personalized care gets proven results.

# Physical Therapy Screening Report

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_____

_____
*Physician Name & Address*

**RE:** _____
*Patient Name, DOB*

Dear _____
*Physician Name*

Your patient, _____, was seen for a screening in our clinic on _____
*Patient Name* *Screening Date*
regarding their _____. Please review the attached form for specific findings from the screening. From the findings, it appears your patient would benefit from physical therapy to address their deficits and limitations.
*Body Part*

## Patient Information

Date of Screen _____ Presenting Problem _____

Onset _____

## Screening Report

Subjective _____

Objective _____

_____

Assessment _____

_____

Plan _____

## Recommendations

Patient could benefit from physical therapy _____ times/week for _____ weeks

Treatment to consist of _____

☐ Therapeutic Exercise ☐ Therapeutic Modalities ☐ Manual Therapy ☐ Soft Tissue/Joint Mobilization

☐ Patient Education ☐ Other _____

Therapist Signature _____ Date _____

Printed Name _____ Phone _____

If you have any questions or concerns, please contact me at your earliest convenience.