BORDER THERAPY SERVICES

Physical Therapy Screening Report

_____

_____

_____
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.