

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
	. Please review the attached form for specific findings from the
	ur patient would benefit from physical therapy to address their deficits and
imitations.	
Patient Information	
	nting Problem
Onset	
Screening Report	
Subjective	
·	
Assessment	
Plan	
Recommendations	
Patient could benefit from physical therapy $_$	times/week for weeks
Treatment to consist of	
\square Therapeutic Exercise \square Therapeutic Moda	alities \square Manual Therapy \square Soft Tissue/Joint Mobilization
\square Patient Education \square Other $___$	
Therapist Signature	Date

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

Printed Name _