



**PHYSICAL THERAPY PRESCRIPTION & REFERRAL FORM**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

**Commonly Used ICD-10 Codes (Check all that apply)**

<input type="checkbox"/>	S06.30 – Unspecified focal traumatic brain injury
<input type="checkbox"/>	Q68.8 – Other specified congenital musculoskeletal deformities
<input type="checkbox"/>	F82 – Specific developmental disorder of motor function
<input type="checkbox"/>	F90 – Attention-deficit hyperactivity disorders
<input type="checkbox"/>	Q90.9 – Down Syndrome, unspecified
<input type="checkbox"/>	R26.89 – Other abnormalities of gait and mobility
<input type="checkbox"/>	S79 – Other and unspecified injuries of hip and thigh
<input type="checkbox"/>	S49 – Other and unspecified injuries of shoulder and upper arm
<input type="checkbox"/>	Q87 – Other specified congenital malformation syndromes affecting multiple systems
<input type="checkbox"/>	G80 – Cerebral palsy
<input type="checkbox"/>	F84.0 – Autistic disorder
<input type="checkbox"/>	R27 – Other lack of coordination
<input type="checkbox"/>	F82 – Specific developmental disorder of motor function
<input type="checkbox"/>	M62.8 – Muscle weakness

**Conditions Commonly Associated with Treatment of Pediatric Patients**

<input type="checkbox"/>	P94.2 – Congenital Hypotonia
<input type="checkbox"/>	M43.6 – Torticollis
<input type="checkbox"/>	R62.5 – Other and unspecified lack of normal physiological development in childhood
<input type="checkbox"/>	R26.2 – Difficulty in walking, not elsewhere classified

**Conditions Commonly Post-Surgical Concerns**

<input type="checkbox"/>	G89 – Pain, not elsewhere classified
<input type="checkbox"/>	M62.4 – Contracture of muscle
<input type="checkbox"/>	R20 – Disturbances of skin sensation

*Other: (please list any specific ICD-10 Code and description)*

\_\_\_\_\_

**Physical Therapy Service(s)**

\_\_\_\_ Evaluation / Treatment      Evaluation Only \_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Physician's Printed Name: \_\_\_\_\_ NPI#: \_\_\_\_\_

***When signed by a physician, this form acts as a prescription for therapy services.  
 Please fax this form along with any additional relevant medical information to 980-938-6088.***

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