



Lynne Marshall-Brook, MS PT, LMT
Jessica Steele-Thornborrow, DPT
Miranda Paasche, DPT

12700 SW Pacific Hwy
Tigard, OR 97223

REFERRAL FORM

(P) 503-753-1537 (F) 503-573-8004
tigardphysicaltherapy.com

PATIENT NAME: _____ DOB: _____
PHONE NUMBER: _____ INSURANCE: _____
DIAGNOSIS: _____ ICD 10: _____

PHYSICAL THERAPY ☐

MASSAGE THERAPY ☐

EVALUATE AND TREAT ☐

VISTS PER WEEK: _____ FOR _____ WEEKS

CORRECTIVE EXERCISE:

BLOODFLOW RESTRICTION ☐

STRENGTH TRAINING ☐ FLEXIBILITY FOCUS ☐

MANUAL THERAPY:

MYOFASCIAL RELEASE ☐ CUPPING ☐ IASTYM ☐

CRANIOSACRAL THERAPY ☐ MANIPULATION ☐

MODALITIES:

SHOCKWAVE ☐ ULTRASOUND ☐ ESTIM ☐

HEAT ☐ ICE ☐ VAGUS NERVE STIMULATION ☐

PELVIC FLOOR REHAB: ☐ BIOFEEDBACK ☐

REFERRING PROVIDER NAME: _____ PHONE: _____

SIGNATURE: _____ DATE: _____

**Please fax this referral form to us with relevant chart notes, imaging reports
and operation reports.**

THANK YOU FOR THIS REFERRAL!