**Physician Referral for Physical Therapy Services**

**STUDENT NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History­­: (Please check all that apply)**

**☐ Asthma ☐ Cardiac**

**☐ Shortness of breath ☐ Nature of cardiac\_\_\_\_\_\_\_\_\_\_\_**

**☐ Stroke ☐ Cancer**

**☐ Seizures ☐ Wear glasses**

**☐ Diabetes ☐ Hearing loss**

**☐ Bleeding Tendency ☐ History of Fractures**

**☐ Scoliosis ☐ Osteoporosis**

**☐ None of the Above**

­­ **List all surgeries and date of surgeries**:

 **List all hospitalizations, date of hospitalizations, and reasons why:**

List all medications and doses:

**☐No past medical history provided-call made on \_\_\_\_\_\_\_\_\_at\_\_\_\_\_\_\_\_by\_\_\_\_\_\_**

**Parents Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IU Physician Signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_