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Doctor of Physical Therapy
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Patient name _____ Date _____

Health Insurance _____

Phone numbers (home) _____ (work) _____
 Please include area code
 (cell) _____ Date of birth _____

Diagnosis	
___ Perineal pain Levator ani syndrome Tension myalgia Vaginismus Vulvodynia Dyspareunia Coccygodynia Episiotomy adhesion Obstructed defecation _____	___ Pelvic pain Endometriosis Interstitial cystitis Abdominal muscle / scar pain Complex pelvic pain _____
___ Pelvic floor muscle (PFM) dysfunction Urinary incontinence Fecal incontinence Pelvic organ prolapse PFM pain _____	___ Pregnancy / postpartum Low back pain Sciatic pain Pubic symphysis _____
___ Lymphedema / Swelling	___ Osteoporosis / Osteopenia

Treatment requested: Physical therapy evaluation and treatment

Other specific treatment _____

Recommended frequency and duration _____

I certify that this treatment is medically necessary for this patient to increase function.

Signature _____ date _____