

# Pelvic Floor Physical Therapy Referral



**HOLOMUA**  
PHYSICAL THERAPY  
MOVE FORWARD

Patient Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Insurance: \_\_\_\_\_

## DIAGNOSIS

- Urinary Incontinence (stress, urge, mixed)
- Fecal incontinence
- Pelvic Organ Prolapse
- Pelvic floor muscle weakness
- Pelvic pain (Vaginal/ Rectal)
- Abdominal pain
- Vaginismus
- Anismus
- Interstitial Cystitis
- SI/ Pubic symphysis dysfunction
- Coccydynia
- Constipation/ Outlet dysfunction
- Other: \_\_\_\_\_

Precautions or Pertinent Medical History:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Physical Therapy \_\_\_\_\_ per week/month  
for \_\_\_\_\_ weeks/months

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

## TREATMENT

- Evaluate and treat
- Manometry/ Biofeedback
- Bladder/ Bowel Retraining
- Visceral mobilization
- Dilator Stretches
- Other: \_\_\_\_\_

\_\_\_\_\_  
Referring M.D.

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