

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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