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WOMEN'S HEALTH REFERRAL

Patient's Name: ______________________ Date: __________

Patient's Phone: ______________________ Patient DOB: __________

Dx: ______________________

OB History: ______________________

Precautions: ______________________

Treatment Schedule:

Frequency: __________ x/week   Duration (# of weeks): __________

PREGNANCY

- ☐ Labor + Delivery Preparation: Pelvic floor muscle training, Posture + Body mechanics and Perineal massage
- ☐ Low Back Pain
- ☐ Pubic Symphysis
- ☐ Carpal Tunnel Syndrome
- ☐ SI Joint Pain
- ☐ Round Ligament Pain
- ☐ Coccygodynia

POST-PARTUM & UROGYNECOLOGY

- ☐ Abdominal Rehab
- ☐ Pelvic Organ Prolapse
- ☐ Interstitial Cystitis
- ☐ Pelvic Floor Muscle Rehab
- ☐ Urethral Syndrome
- ☐ Post Radiation Issues
- ☐ Diastasis Recti
- ☐ Frequency/Urge Syndrome
- ☐ Vaginismus
- ☐ C-Section Rehabilitation
- ☐ Post-Surgical Issues
- ☐ Vulvodynia
- ☐ Stress Urinary Incontinence
- ☐ Levator Ani Syndrome
- ☐ Bowel Issues
- ☐ Dyspareunia
- ☐ Pudendal Neuralgia

I hereby certify that the above services have been deemed medically necessary.

Physician's Name: ______________________ Date: __________

Physician's Signature: ______________________

Please include a copy of the surgery or imaging report if appropriate.