|  |  |
| --- | --- |
| Referral Form: Annual Physical Therapy Visit for Aging Adult |  |

|  |  |  |
| --- | --- | --- |
| **Screenings**  | At Risk | **Referral** |
| **Balance and falls.** | [ ]  | **Physical therapy**Click or tap here to enter text.**(PT name, date, time)****Other health care provider**Click or tap here to enter text.**(Provider name and contact information)****Physical activity program**Click or tap here to enter text.**(Program name and contact information)****Follow-up to annual visit**Click or tap here to enter text.**(PT Name, date, time)** |
| **Mobility limitations.** | [ ]  |
| Walking speed. | [ ]  |
| Walking distance. | [ ]  |
| Sit to stand from chair. | [ ]  |
| Squatting and picking up objects from floor. | [ ]  |
| Grasping, lifting, and carrying objects. | [ ]  |
| Physical fitness. | [ ]  |
| Cardiovascular endurance. | [ ]  |
| Flexibility. | [ ]  |
| Sedentary lifestyle. | [ ]  |
| Not meeting guidelines for physical activity. | [ ]  |
| Reason for Referral: Click or tap here to enter text.Click or tap here to enter NAME., PT, Click to add ACADEMIC, REGULATORY DESIGNATIONS.Board-Certified Clinical Specialist in Geriatric Physical Therapy (if applicable) Click to add NAME OF CLINIC OR FACILITY.Click to add ADDRESS.Click or tap here to enter EMAIL.Click or tap here to enter PHONE NUMBER. |

**Template Last Updated:** 10/04/2021

**Contact:** practice@apta.org