The Integrated Feminine
Specialized Pelvic Floor Therapy
2738 NE Broadway St., Portland, OR 97217
Phone: (971) 337-6372
Fax: (503) 914-1912
www.integratedfeminine.com

Physical/Occupational Therapy Referral Form
Pelvic Floor Therapy Specialized OT

_____

Patient Name Patient Phone Number

_____

Diagnosis/ICD Date of Birth

Occupational Therapy Treatment Order:

___Evaluate and Treat
___Manual Therapy
___Therapeutic Exercise
___Per Therapist Discretion
___Biofeedback
___Home Exercise Program

Specific Instructions/Precautions: _____

Diagnoses/Problems: (for female AND male patients)

____Pelvic Pain (R10.2)
____Hip Pain(M25.55)
____Sciatica (M54.3)
____Neuralgia (M79.2)
____Pubic Symphysis Diastasis(026.73)
____Slow Transit Constipation (K59.01)
____Painful Defecation (R30.0)
____Incomplete Defecation (R15.0)
____Urinary Urgency(R39.15)
____Poor/Weak Stream (R39.12)
____Vulvadynia (N94.819)
____Abdominal adhesion/ restriction(K66.0)
____Pelvic Muscle Wasting (N81.84)
____Rectus Diastasis(R14.0)
____Dysmennorhea (N94.6)
____Abdominal Pain(R10.9)
____Lumbar/Flank Pain (M54.5)
____Thoracic Pain (M54.6)
____Sacrococcygeal disorder (M 53.3)
____Headache (784.0)
____Fecal Incontinence(R15.9)
____Outlet Obstruction Constipation (K59.02)
____Urge Incontinence(N39.41)
____Stress Incontinence (N39.3)
____Painful Urination(R30.0)
____Perineal body tear/laceration(070.9)
____Prolapse (N81.1)
____Irritable Bowel (K58)
____Abdominal Bloating (R14.0)
____Scarring condition (L90.5)

Other: _____

Frequency:	___1x/week	___2x/week	___Per Therapist Discretion
Duration:	___6 weeks	___12 weeks	___Per Therapist Discretion

_____

Physician Signature Date of Referral Office Phone Office Fax

TO SCHEDULE, PLEASE CALL (971) 337-6372 & fax (503) 914-1912 or scan/email form to info@integratedfeminine.com