Date: [Date]

To: [Physical Therapist Name/Facility Name]
Address: [Facility Address]
Phone/Fax: [Phone/Fax Number]

RE: Patient Physical Therapy Referral
Patient Name: [Patient Name]
Date of Birth: [DOB]
Phone: [Patient Phone Number]

Dear Physical Therapist,

I am referring this patient for a comprehensive physical therapy evaluation and treatment due to an increased risk of falls. The patient has clinical indicators suggesting a need for professional intervention to improve safety and mobility.

Reason for Referral:

- History of recent falls (Number of falls: [Number])
- Difficulty with balance and gait
- Muscle weakness and deconditioning
- Fear of falling resulting in decreased activity
- [Additional Reason]

Medical Diagnoses/Co-morbidities:

[List relevant diagnoses, e.g., Osteoarthritis, Neuropathy, Vertigo]

Requested Services:

- Fall Risk Assessment (TUG, Berg Balance, etc.)
- Gait and Balance Training
- Lower Extremity Strengthening
- Home Safety Education
- Vestibular Rehabilitation (if applicable)

Frequency/Duration: [e.g., 2-3 times per week for 8 weeks]

Please provide a copy of your initial evaluation and periodic progress reports to my office via fax at [Fax Number].

Thank you for your assistance in this patient's care.

Sincerely,

[Referring Provider Name]
[Provider Signature/Credentials]
[Practice Name]
[Phone Number]