



CORRECTIVE
BODYWORKS
CLINICAL MASSAGE + SPORTS MEDICINE

Jeffrey N. Cotten, PTA, AT, CES, LMT

- Physical Therapist Assistant
- Certified Athletic Trainer
- Corrective Exercise Specialist
- Licensed Massage Therapist

License #

Referral

Client/Athlete Name: _____ Date of Birth: _____

Reason for Referral: _____

Physician Name(please print): _____ Phone: _____

Physician Fax: _____ Physician Email: _____

Return to Physician: _____

Please Indicate the Services/Treatments Requested: **Evaluate and Treat**

Soft tissue/Fascial Manipulation Corrective Exercise Manual stretching/ROM

Soft tissue/Joint Mobilization Neuromuscular Re-education

Performance/Functional Testing Sport Specific Rehabilitation

(Please specify injury/
complaint): _____

Modalities

Electrical Stimulation Ultrasound Heat Cold/Vasocompression

Kinesiology Taping Orthotics/Splinting

Frequency 1 2 3 4 5 Times per week

Duration 2 4 6 8 Weeks. Other: _____

I certify that the client/athlete would benefit from the services listed above, or those at the discretion of the Athletic Trainer/Massage Therapist. The client/athlete has the following known medical condition, _____, but is approved to begin treatment consisting of the services indicated above.

Physician Signature: _____

Date: _____

