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Duncan Mitchell, PT, DPT, OCS · Stephen Mitchell, PT, MPT · Tarah Hoelter, PT, DPT, OCS

PHYSICAL THERAPY REFERRAL FORM

Date: _____

Patient Name: _____

Patient Phone: _____

Diagnosis/ICD-10: _____

Special Instructions: _____

Treat: _____ times per week for _____ weeks

or _____ total visits

Physician's Signature: _____

Print Physician Name: _____

Physician follow-up Date: _____

Providers For:

ACN (Optum Health), Beechstreet, Caremark Comp, Champ VA, Cigna, CorVel-PPO, First Choice, Heath Management Network (HMN), Healthnet, Integrated Health Plan (IHP), Liberty Mutual, Managed Healthcare NW (MHN), Medicare, Moda, North Clackamas School District, Pacific Source, Private Healthcare Systems (PHCS), Regence / Blue Cross Blue Shield, SAIF-Workers Compensation, Tricare/Triwest, United Healthcare

Out of Network Provider Benefits Only:

Aetna, Greatwest, Kaiser, Providence Health Plan-open option

Please check with your insurance regarding your physical therapy benefits.



Memberships with

