



Pelvic Floor Physical Therapy Referral Form

Patient Name: _____ Date of Birth: _____

Patient's Phone Number: _____

Evaluate and Treat

Contact Prior to Evaluation

Diagnosis: _____

Reason for Referral (check all that apply):

- | | |
|----------------------------------|-----------------------------|
| Pelvic Floor Muscle Weakness | Defecatory Dysfunction |
| Pelvic Floor Myalgia/Spasm | Fecal Incontinence |
| Urinary Incontinence | Anorectal Pain |
| Voiding Dysfunction | Pelvic Pain |
| Urinary Urgency and/or Frequency | Abdominal Pain |
| Urinary Retention | Low Back Pain |
| Pelvic Organ Prolapse | Dyspareunia |
| Pre- or Post-surgery | Vaginismus |
| Pregnancy/Postpartum | Genital Hyperarousal |
| Scar Tissue/Adhesions | Vulvodynia/Vestibulodynia |
| Diastasis Recti | IC/Painful Bladder Syndrome |
| SIJ/Pelvic Girdle Pain | Pudendal Neuralgia |
| Pubic Joint Pain | Endometriosis/Adenomyosis |
| Coccydynia | Chronic Prostatitis/CPSP |
| Constipation | |

Additional Information (Precautions, Testing, Surgery, Other):

Physician Signature: _____

Physician Name: _____ Date: _____