Bethany Hansen, LLC

Physical Therapy Referral Form

Bethany Hansen, PT, DPT

Fax To: (612) 808-0365

Patient Name: _____ Date of Birth: _____

Patient's Phone Number: _____

☐ Evaluate and Treat ☐ Contact Prior to Evaluation

Diagnosis: _____

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

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

_____

Physician Signature: _____

Physician Name: _____ Date: _____

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