KEMENTERIAN KESIHATAN MALAYSIA
PHYSIOTHERAPY REFERRAL FORM

NAME : ______________________ CLINIC/UNIT/WARD : ________ RN NO : __________

AGE : ______ DATE OF BIRTH : ______________________ GENDER : __________ RACE : ________________

IC.NO / PASSPORT : ____________________ TELEPHONE NO / HP : ______________________________

ADDRESS : ____

PATIENT'S PARTICULARS

PATIENT'S HISTORY & DIAGNOSIS :

INVESTIGATIONS:

PRECAUTIONS IF ANY:

PHYSIOTHERAPY INTERVENTIONS

☐ CHEST PHYSIOTHERAPY	☐ AMBULATION	☐ CARDIAC REHABILITATION
☐ THERAPEUTIC EXERCISES	☐ GAIT TRAINING	☐ NEURO REHABILITATION
☐ PAIN MANAGEMENT	☐ BALANCE TRAINING	☐ VESTIBULAR REHABILITATION
☐ ELECTRICAL MODALITIES	☐ LYMPHOEDEMA THERAPY	☐ BURN REHABILITATION
☐ ELECTRICAL STIMULATION	☐ C OMPRESSION BANDAGING	☐ SPINAL REHABILITATION
☐ MANUAL THERAPY	☐ CONTINENCE THERAPY	☐ HAND REHABILITATION
☐ HOT PACK / WAX BATH	☐ PHOTOTHERAPY	☐ AMPUTEE REHABILITATION
☐ CRYOTHERAPY	☐ EARLY INTERVENTION PROGRAM	☐ EDUCATIONAL CLASS
☐ HYDROTHERAPY	☐ NEURO-DEVELOPMENTAL THERAPY	☐ HEMOPHILIA REHABILITATION
☐ TAPPING/STRAPPING	☐ OBESITY PROGRAMME	☐ PULMONARY REHABILITATION
☐ PALLIATIVE CARE	☐ DRY NEEDLING	☐ OTHERS (*Please specify*) :- __________
☐ SPORT INJURIES MANAGEMENT	☐ PEOPLE WITH ARTHRITIS CAN EXS	

SIGNATURE OF SPECIALIST / MEDICAL OFFICER

NAME : SIGNATURE :

DATE : STAMP :

OFFICIAL USE

(FORM RECEIVED STAMP/INITIAL/TIME RECEIVED)	STAFF'S ACTION (DATE/ TIME/INITIAL/STAMP)	REMARKS

Referral letter is ONLY VALID for 1 month from date of referral. (Rujukkan ini SAH LAKU selama 1 bulan daripada tarikh rujukan)