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

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)