SynerG Pelvic Health and Physical Therapy Referral Form

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PATIENT NAME: _____ DOB: _____
DIAGNOSIS/ICD-10: _____

I. SPECIALIZED BOWEL & RECTAL REHAB

(Targeting Post-Surgical Dysfunction, Urgency, & Dyssynergia)

[ ] **Comprehensive Pelvic Floor Eval & Treat**

[ ] **Rectal Balloon Biofeedback / Sensory Retraining**

[ ] **Post-Surgical Bowel Rehabilitation** (Bowel Resection/Ostomy Takedown)

[ ] **Defecation Coordination Training** (Chronic Constipation/Straining)

II. WOMEN'S & MEN'S PELVIC HEALTH

[ ] **Pelvic Pain & Dyspareunia** (Endometriosis, Prostatitis, CPPPS, Coccydynia, Post Hysterectomy)

[ ] **Urinary Dysfunction** (Stress/Urge/Mixed Incontinence)

[ ] **Pregnancy & Postpartum Rehab** (Diastasis Recti, Pelvic Girdle Pain, Child Birth Prep)

[ ] **Pre- & Post-Prostatectomy Rehab** (Incontinence & ED Management)

[ ] EVALUATE AND TREAT (Frequency: ____ x week for ____ weeks)

Physician Signature: _____ Date: _____
NPI: _____