



PHYSICIAN REFERRAL

Patient's Name: _____

Diagnosis: _____

Precautions: _____

- Evaluate and Treat
- Home Program
- Work/Functional Conditioning
- Therapeutic Exercise
- Modalities
- Other _____

Comments: _____

Frequency: ____ x week ____ weeks or ____ visits total

Signature: _____

Date: _____

Clinics

Chesterton Clinic
425 Sand Creek Dr N
#C
Chesterton, IN 46304
(219) 926-9779

Michigan City Clinic
320 Dunes Plaza
Michigan City, IN 46360
(219) 898-4360