



PHYSICAL THERAPY
& SPORTS MEDICINE

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

La Jolla

8950 Villa La Jolla Dr
A125

La Jolla , CA 92037
(858) 452-3502

Mission Valley

7840 Mission Center Ct
#103

San Diego, CA 92108
(619) 294-3644