



## 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**

#### **Scottsdale**

16700 N Thompson  
Peak Pkwy #220  
Scottsdale, AZ 85260  
(480) 629-4606

#### **Chandler**

575 W Chandler Blvd  
#129  
Chandler, AZ 85225  
(480) 629-8720