PROGRESSIVE
Physical Therapy

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

Seymour
321 W Bruce St Suite B
Seymour, IN 47274
(812) 522-7887

Columbus
2475 North Park Suite 20
Columbus, IN 47203
(812) 372-7800

Greensburg
930 E Barachel Lane
Suite 400
Greensburg, IN 47240
(812) 663-5072