

# Thrive 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

#### Atlanta Clinic

275 Carpenter Dr NE,  
Suite 210  
Atlanta, GA 30328  
(404) 565-2266

#### Savannah

511 E 63rd St  
Savannah, GA 31405  
(912) 604-4037