



Helping you with your particular needs and physical therapy goals.

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

Paradise
6678 Clark Road
Paradise, CA 95969
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2623 Forest Avenue
Chico, CA 95928
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2858 Olive Hwy
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