PROMOTION 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

North Central
15614 Huebner Road, Ste. 115
San Antonio, TX 78248
(210) 479-3334

Westover Hills
10415 State Hwy 151, Ste 101
San Antonio, TX 78251
(210) 647-9970

Medical Center
9502 Huebner Rd., Bldg 301
San Antonio, TX 78240
(210) 478-5486

Stone Oak/ TPC
3111 TPC Pkwy Ste 112
San Antonio, TX 78259
(210) 257-8272