Back 2 Health
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

Los Angeles/Hollywood
1335 N La Brea Ave
Suite 3
Los Angeles, CA 90028
(310) 246-1050

Burbank
930 W Alameda Ave
Burbank, CA 91506
(818) 588-3880

Encino
17227 Ventura Blvd
Encino, CA 91316
(818) 990-9930

Irvine
12 Mauchly Suite A
Irvine, CA 92618
(949) 288-4235