PHYSICAL THERAPY ONE

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

Portage
1423 W. Centre Ave
Portage, MI 49024
269.323.4300

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3282 Stadium Dr
Kalamazoo, MI 49008
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13329 Portage Rd
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