

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

Queensbury

3 Hunter Brook Lane
Queensbury, NY 12804
(518) 793-0891

South Glens Falls

1391 Rt 9
Gansevoort, NY 12831
(518) 793-6333