Physical Rehabilitation Services

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

Ross Township
1033 Perry Hwy
Pittsburgh, PA 15237
(412) 366-3880

Franklin Park Corporate Center
2400 Corporate Dr #201
Wexford, PA 15090
(724) 940-3990