Integrated Therapy Practice P.C.

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

Hobart
1265 S. Lake Park Ave.
Hobart, IN 46342
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521 E. 86th Ave., Suite J
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(219) 736-2801

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(219) 531-1756

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3108 Santa Barbara Blvd, Suite 108
Cape Coral, FL 33914
(239) 257-1431