



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

Big Rapids

1268 W. Perry Avenue
Big Rapids, MI 49307
231-796-4419

Clare

107 Schoolcrest Ave.
Clare, MI 48617
989-386-9170

Gladwin

1206 North State St.
Gladwin, MI 48624
989-246-2311

Harrison

158 North First St., Ste
D
Harrison, MI 48625
989-539-4167

Midland

2600 N Saginaw Road,
Ste C
Midland, MI 48640
989-837-1529