COMPLETE REHAB

YOUR PHYSICAL THERAPY SOLUTION

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

Troy West
1380 Coolidge Hwy Ste 180
Troy, MI 48084
(248) 712-4400

Warren
28569 Schoenherr Rd
Warren, MI 48088
(586) 576-7000

Livonia
20278 Middlebelt Rd
Ste 600
Livonia, MI 48152

Clinton Township
42645 Garfield Rd Ste 104
Clinton Township, MI 48038
(586) 229-2293