



## 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

#### **Pikeville**

175 Weddington  
Branch Rd  
Pikeville, KY 41501  
(606) 637-1830

#### **Prestonsburg**

83 Dewey Street  
Prestonsburg, KY  
41653  
(606) 886-9888

#### **Paintsville**

515 Broadway Street  
Paintsville, KY 41240  
(606) 789-7201