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

Avon Clinic
50 Buck Creek Road
Suite 210
Avon, CO 81620
(970) 470-4023

Edwards Clinic
1140 Edwards Village
Blvd, Suite B208
Edwards, CO 81632
(970) 569-3883