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

West Wichita Clinic
7340 W 21st St N, Ste 100
Wichita, KS 67205
(316) 613-3068

Valley Center Clinic
1220 S Meridian, Ste E
Valley Center, KS 67147
(316) 636-7699