



## 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