



HOOSIER

PHYSICAL THERAPY

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

Hoosier Clinic

3030 Lake Ave #26
Fort Wayne, IN 46805
(260) 420-4400

Kendallville Clinic

621 W North St
Kendallville, IN 46755
(260) 343-0343