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

Lake Wales Clinic
1750 Longleaf Blvd,
Suites 5 & 6
Lake Wales, FL 33859
(863) 678-0705

Haines City Clinic
50 Maxcy Plaza Circle
Haines City, FL 33844
(863) 421-2000