

## Palo Cedro 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

**Palo Cedro** 22038 Old 44 Dr Palo Cedro, CA 96073 (530) 547-3220