

## PHYSICIAN REFERRAL

Patient's Name: Diagnosis: Precautions:			
		Com	Evaluate and Treat  Home Program  Work/Functional Conditioning Therapeutic Exercise Modalities Other
		Freq	uency: x week weeks or visits total
Sign	ature:		
Date	:		

## **Clinics**

**Hale** 3076 Northridge Road Hale, MI 48739 (989) 728-0242