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

Wheeling (Bethlehem)
1086 E Bethlehem Blvd
Wheeling, WV 26003
(304) 238-9468

Washington
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#903
Washington, PA 15301
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1817 Warwood Ave
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(304) 905-8072