

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

Yorktown Heights 48 Route 6 Yorktown Heights, NY 10598 (914) 302-2190