



Integrated Therapy Practice P.C.

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

Merrillville

521 E. 86th Ave., Suite J

Merrillville, IN 46410

(219) 736-2801

Cape Coral

2002 Del Prado Blvd S Suite 102

Cape Coral, FL 33990

(239) 257-1431