



Suncare Therapy, Inc.

Clinical Services Group

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

Miami Lakes Clinic

15524 NW 77th Ct
Miami Lakes, FL 33016
(305) 231-5266

Miami

1251 NW 36 St
Miami, FL 33142
(305) 231-5266