

PHYSICAL THERAPY ▪ WOMEN’S HEALTH ▪ GOLF FITNESS

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**PHYSICIAN REFERRAL FOR OUTPATIENT PHYSICAL THERAPY**

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DATE: \_\_\_\_ /\_\_\_\_ / \_\_\_\_\_

NAME OF PATIENT:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ /\_\_\_\_

DIAGNOSIS:

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□ Evaluate + treat □ Manual Therapy ADDITIONAL INSTRUCTIONS

□ Therapy exercise \_\_\_ ASTYM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Neuro Re-ed \_\_\_Joint mobs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other \_\_\_STM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PHYSICIAN NAME PHYSICIAN SIGNATURE