



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

Massapequa

913 N Broadway
North Massapequa, NY
11758
(516) 454-6387

Lake Grove

2848 Middle Country Rd
Lake Grove, NY 11755
(631) 780-5550