



SUMMIT
PHYSICAL THERAPY
Restoring the good life.

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

Jefferson Blvd Clinic
7513 W Jefferson Blvd
Fort Wayne, IN 46804
(260) 206-6164

Lima Rd Clinic
6210 Lima Rd
Fort Wayne, IN 46818
(260) 484-9491