



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

Ridgewood Clinic
68-05 Fresh Pond Rd
Ridgewood, NY 11385
(718) 456-2545

Astoria Clinic
46-18 Broadway
Astoria, NY 11103
(718) 274-4200

Greenpoint Clinic
1007 Manhattan Ave
Greenpoint, NY 11222
(718) 383-7361

Jackson Heights
92-16 Roosevelt Ave
Jackson Heights, NY
11372
(718) 426-2100

Wyckoff - St. Nicholas
201 St Nicholas Ave
Brooklyn, NY 11237
(718) 821-9511

Steinway Clinic
25-49 Steinway St
Astoria, NY 11103
(718) 726-2470

Metropolitan Clinic
75-18 Metropolitan Ave
Middle Village, NY
11379
(718) 568-6633

Flushing Clinic
57-21 Main St
Flushing, NY 11355
(929) 432-5500

Graham Clinic
154 Graham Ave
Brooklyn, NY 11206
(929) 458-6840

Lefferts
133-57 Lefferts Blvd Fl
Queens, NY 11420
(718) 218-5397

Elmhurst
6008 Junction Blvd Unit
A-1
Elmhurst, NY 11373
(929) 388-7100

Wyckoff Annex
199 St Nicholas Ave
Brooklyn, NY 11237
(646) 687-0380