

# 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

**Wilmington Oleander**  
5710 Oleander Dr #211  
Wilmington, NC 28403  
(910) 398-6301

**Hampstead**  
14057 Hwy 17 N Suite  
230  
Hampstead, NC 28443  
(910) 821-3377

**Live Well Medical  
Wellness**  
5710 Oleander Dr #212  
Wilmington, NC 28403  
(910) 398-6301

**Leland**  
497 Olde Waterford  
Way Suite 102  
Leland, NC 28451  
(910) 444-1548

**Wilmington-  
Midtown/Shipyard**  
2250 Shipyard Blvd  
Suite 14  
Wilmington, NC 28403  
(910) 518-9951