HPT
PHYSICAL THERAPY

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

Pikeville
175 Weddington Branch Rd
Pikeville, KY 41501
(606) 637-1830

Prestonsburg
83 Dewey Street
Prestonsburg, KY 41653
(606) 886-9888

Paintsville
515 Broadway Street
Paintsville, KY 41240
(606) 789-7201