



PHYSICAL THERAPY  
& SPORTS MEDICINE

## 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

#### **La Jolla**

8950 Villa La Jolla Dr  
A125

La Jolla, CA 92037  
(858) 452-3502

#### **Mission Valley**

7840 Mission Center Ct  
#103

San Diego, CA 92108  
(619) 294-3644