



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

West Wichita Clinic
7340 W 21st St N, Ste
100
Wichita, KS 67205
(316) 613-3068

Valley Center Clinic
1220 S Meridian, Ste E
Valley Center, KS
67147
(316) 636-7699