



**OUACHITA &
WINNSBORO**
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

Ouachita Clinic
1138 Oliver Rd
Monroe, LA 71201
(318) 323-3031

Winnsboro Clinic
710 Prairie St
Winnsboro, LA 71295
(318) 435-3882