LIVE WELL 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

**Southeast Grand Island**
929 S Locust St
Grand Island, NE 68801
(308) 382-9700

**Northwest Grand Island**
3537 W 13th St #104
Grand Island, NE 68803
(308) 318-5354

**Live Well Sports and Performance Center**
2517 Old Potash
Grand Island, NE 68803