



GAINES 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

Benson

995 W 4th St Ste G
Benson, AZ 85602
(520) 237-8091

Sonoita Clinic

542 Harshaw Ave
Patagonia, AZ 85624
(520) 237-8091