



Physical, Speech & Sports 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

South Clinic
105 Mariner Health Way, Suite 213
St. Augustine, FL 32086
(904) 217-4259

Central Clinic
65 Strongway Ct
St. Augustine, FL 32086
(904) 679-3204

World Golf Clinic
475W Town Place, Suite 100
St. Augustine, FL 32092
(904) 481-8747

Island Clinic
4299 SR-A1A S
St Augustine, FL 32080
(904) 679-3449

Parkinson's Neurological Health Center
1711 Lakeside Ave Suite 3
St Augustine, FL 32084
(904) 201-1080