



## 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

**Rock Springs**  
1977 Dewar Drive  
Suite J  
Rock Springs, WY  
82901  
(307) 382-3228

**Lyman**  
109 South Main Street  
Suite D  
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(307) 787-3278

**Green River**  
2100 W Teton Blvd  
Green River, WY 82935  
(307) 875-1788