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

Physical Therapy - Indian Wells
1809 Indian Wells Rd
Alamogordo, NM 88310
(575) 437-1967

Occupational & Speech Therapy - Galloway Drive Location
1451 Galway Dr
Alamogordo, NM 88310
(575) 495-2880