



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

**Pool Location -
Temporarily Closed**
12171 World Trade Dr
San Diego, CA 92128
(858) 675-1133

Main Office
15373 Innovation Dr
#175
San Diego, CA 92128
(858) 675-1133

**Healing Wave
Aquatics**
2657 Ariane Dr
San Diego, CA 92117
(858) 675-1133