



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

DHDPT - Bayou Ln
808 Bayou Ln
Thibodaux, LA 70301
(985) 447-3164

**DHDPT - Grand
Caillou Rd**
1321 Grand Caillou Rd
Houma, LA 70363
(985) 876-1155

**DHDPT - Bayou
Gardens Blvd**
125 Bayou Gardens
Blvd
Houma, LA 70364
(985) 223-4760