Physician Referral

Patient's Name: ____________________

Diagnosis: ____________________

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Precautions: ____________________

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- ☐ Evaluate and Treat
- ☐ Home Program
- ☐ Work/Functional Conditioning
- ☐ Therapeutic Exercise
- ☐ Modalities
- ☐ Other ____________________

Comments: ____________________

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Frequency: ____ x week ____ weeks or ____ visits total

Signature: ____________________

Date: ____________________

Clinics

Brooklyn
8616 3rd Ave
Brooklyn, NY 11209
(718) 833-4656

Astoria
30-63 38th St
Astoria, NY 11103
(718) 932-1269