



**FOOTHILLS**  
PHYSICAL THERAPY GROUP

## PHYSICIAN REFERRAL

### Clinic

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: \_\_\_\_\_

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