Twin Lakes
PHYSICAL THERAPY

# 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**

**Gray**
222 W Clinton St #3
Gray, GA 31032
(478) 986-5400

**Milledgeville**
641 W Thomas St
Milledgeville, GA 31061
(478) 452-6252