elite
Sports Medicine | Physical Therapy

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personalized
precise
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PHYSICAL THERAPY REFERRAL

PATIENT NAME _____

DATE OF BIRTH _____

DIAGNOSIS _____

NEXT PHYSICIAN
APPOINTMENT DATE _____

evaluation

☐ EVALUATE AND TREAT _____

☐ SOCIAL/VOCATIONAL EVALUATION

☐ SPECIAL INSTRUCTIONS/PRECAUTIONS _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

frequency

☐ THERAPIST DISCRETION/PRN

☐ _____ TIMES PER WEEK FOR _____ WEEKS

PHYSICIAN SIGNATURE _____

In making this referral, the physician has determined that the above care is a medical necessity.

referral