

## 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

**Los Angeles /  
Hollywood**

1335 N La Brea Ave  
Suite 3  
Los Angeles, CA 90028  
(310) 246-1050

**Burbank**

930 W Alameda Ave  
Burbank, CA 91506  
(818) 588-3880

**Encino**

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Encino, CA 91316  
(818) 990-9930