



IS NOW



FYZICAL

Therapy & Balance Centers

**Next to Dynamic Health and Fitness
in Lexington, SC**

DATE: _____

PATIENT INFORMATION:

Name _____

Diagnosis/Condition _____

Precautions _____

If the referral is being faxed, please provide the following patient information and include a copy of the insurance card

Phone _____

DOB _____

INSTRUCTIONS:

- Evaluate and Treat
 - Work Conditioning
 - Fall Risk Assessment
 - Other _____
- Body Mechanics / Lifting Techniques
- Return to sports assessment
- Iontophoresis/Iontopatch 4mg/ml dexamethasone

TREATMENT PLAN:

- Therapist's Discretion
 - _____ days/week for _____ weeks

PHYSICIAN'S NAME PRINTED: _____

PHYSICIAN'S SIGNATURE: _____

Thank you for this referral!