FYZICAL® Therapy & Balance Centers

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PHYSICAL THERAPY REFERRAL

Patient Name: _____ DOB: _____

Diagnosis: _____ Referral Date: _____

Date of Injury: _____ Next MD Appointment: _____

Surgery Date: NA or _____ Phone: _____

Physical Therapy	OT/Hand Therapy	Balance/Vestibular Therapy
☐ Evaluation and Treatment	☐ Evaluation and Treatment	☐ Evaluation and Treatment
OR ☐ Per Protocol	OR ☐ Per Protocol	OR ☐ Per Protocol

Frequency

☐ Per Therapist Discretion OR _____ times a week for _____ weeks

Special Instructions or Precautions: _____

_____

Physician Signature: _____ Printed Physician Name: _____

Specialty Programs

- Orthopedic Rehabilitation
- Neurological Rehabilitation
- Balance & Vestibular Therapy
- Post-Surgical Rehabilitation
- Dry Needling
- Pediatrics
- Pelvic Floor
- Work Conditioning