PLEASE BRING THIS FORM TO YOUR PHYSICIAN FOR SIGNATURE

FYZICAL®
Therapy & Balance Centers

7257 Center St, Mentor Phone: 440-740-8877 Fax: 440-740-8844

REFERRAL FOR PHYSICAL THERAPY

Name: _____

Today's Date: _____ Date of Birth: _____

Diagnosis: _____

Name of Physician (please print): _____

Physician Signature: _____

Special Instructions: _____

_____

_____

- ☐ Eval & Treat
- ☐ Back Pain
- ☐ Gait Training
- ☐ Vertigo and BPPV
- ☐ Baseline Concussion Testing
- ☐ Post Concussion Syndrome
- ☐ POTS/Dysautonomia
- ☐ Balance Training
- ☐ Other: _____
- ☐ Neck Pain
- ☐ Headaches
- ☐ Joint Pain and Arthritis
- ☐ Stroke Rehabilitation
- ☐ Parkinson's Therapy/LSVT
- ☐ TMJ Rehabilitation
- ☐ Vestibular Rehabilitation
- ☐ Chronic Pain

Spelled Different, Because We Are Different