

Physician's Referral

Patient's Name:

Date:

Diagnosis:

Precautions:

Please check all that apply:

Evaluate and Treat

Pelvic Pain Treatment

Incontinence Treatment Program

Pregnancy/Back Pain Treatment

Lymphedema

Osteoporosis Program

Back Pain/SI Pain

Other:

Comments:

Frequency: _____ times a week for _____ weeks.

Due to the condition of this patient, it is a medical necessity that she receives this treatment.

Physician's
Signature:

Date: