



SPORTS & WELLNESS
PHYSICAL THERAPY

2015-B South Broadway · Santa Maria · CA 93454 (at Family Health and Fitness)
Phone: (805) 922-4676 · Fax: (805) 922-5854

DOUGLAS B. JOHNSON, P.T.

REFERRAL FOR
PHYSICAL THERAPY

DATE: _____

Patient Name _____

Diagnosis _____ DOB _____

Frequency _____ x/week Duration _____ weeks

Precautions _____

Evaluate and Treat

Programs:

- | | |
|-----------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Neck | <input type="checkbox"/> Balance Program |
| <input type="checkbox"/> Back | <input type="checkbox"/> Aquatic Therapy |
| <input type="checkbox"/> Joint | <input type="checkbox"/> Gym Program |
| <input type="checkbox"/> Modalities as needed | <input type="checkbox"/> Home Exercise Program |

Other _____

I certify that I have examined the patient and have determined that
physical therapy is medically necessary.

Signature : _____

(please print)

Thank You For Your Referral