YOUR SOUTH KNOXVILLE CHOICE

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Physical Therapy Referral

Fax 865-577-8147

PATIENT INFORMATION

Name____

Diagnosis/Condition______________________________

TREATMENT PLAN

☐ Evaluate and Treat

☐ Custom Orthotics

☐ Modalities ____________________

☐ Exercises ____________________

☐ Western Dry Needling

Frequency ______ days/wk   Duration ______ wks

Special Instructions/Precautions ____________________

____

Physician's Name____________________________________
(please print)

____
Physician's Signature   Date

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Please fax patient demographics and insurance information, or complete the information below.

DOB _________ - _________ - _________

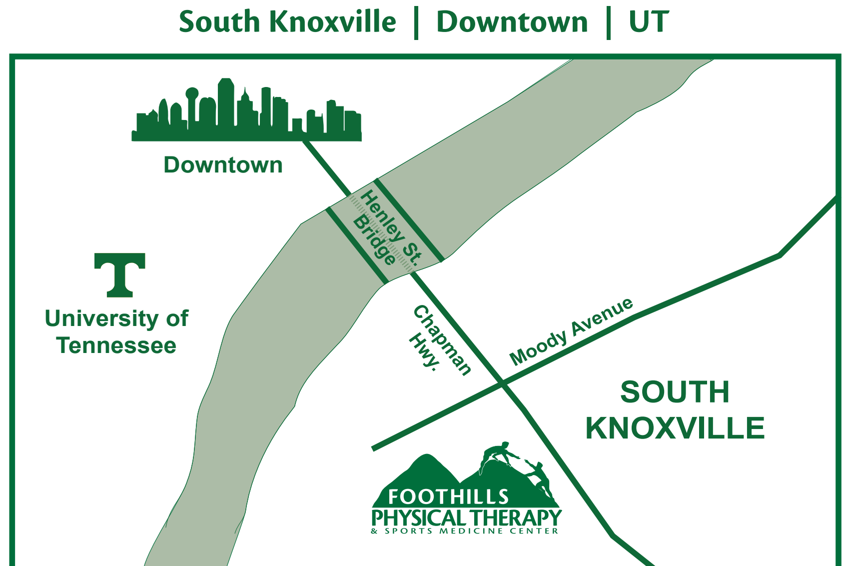
Phone ____________________________

Health Insurance Co.

____

ID# ____________________________

South Knoxville | Downtown | UT



1.3 miles from Henley Street Bridge

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Notes / Special Instructions:

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