



**Jennifer R. Shepherd, PT, CLT-LANA**  
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**Referral for Physical Therapy**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Patient Home Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

Insurance: \_\_\_\_\_

Evaluate and Treat \_\_\_\_\_

Physical Therapy Orders: \_\_\_\_\_

Additional Comments/Precautions: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Print Name

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_