



Inside New Life Fitness World  
Lexington, SC

DATE: \_\_\_\_\_

**PATIENT INFORMATION:**

Name \_\_\_\_\_

Diagnosis/Condition \_\_\_\_\_

Precautions \_\_\_\_\_

If the referral is being faxed, please provide the following patient information and include a copy of the insurance card

Phone \_\_\_\_\_

DOB \_\_\_\_\_

**INSTRUCTIONS:**

Evaluate and Treat

Aquatic Therapy

Work Conditioning

Fall Risk Assessment

Other \_\_\_\_\_

Body Mechanics / Lifting Techniques

Return to sports assessment

Iontophoresis/Iontopatch 4mg/ml  
dexamethasone

**TREATMENT PLAN:**

Therapist's Discretion

\_\_\_\_\_ days/week for \_\_\_\_\_ weeks

PHYSICIAN'S NAME PRINTED: \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_

*Thank you for this referral!*