Alliance Therapy Services

12320 Hwy. 44, Building 3-F
Gonzales, LA 70737

PHYSICIAN REFERRAL FORM

(225) 647-9505 • Fax (225) 647-9503

Patient Name ____

Phone #____

Diagnosis: ____

_________ PT _________ Hand _________ OT _________ Speech _________ ASTYM

_________ Evaluate and Treat _________ Continue Therapy

_________ Specific Order

_________ Therapeutic Exercise _________ Electrical Stimulation

_________ Massage _________ Phonophoresis

_________Ultrasound _________ ASTYM

_________ Moist Heat _________ Iontophoresis

COMMENTS ____

____

Frequency Duration _________ x week for _________ weeks

______________________________ _______________
Physician's Signature Date

____
Print Physician's Name

★ **Please fax order to our office**