Physician Referral Form

First Name:_____ Last Name: _____

DOB:_____

Referring Physician Information Physician Name: Address:	Physician Phone: Physician Email: Primary Contact Name:

Major Complaint:

Special Instructions, Recommended Precautions and Comments:

By my signature below, I affirm that I know of no reason why the applicant should not participate in therapeutic yoga, and I hereby medically release him / her to do so.

Physician's Signature:_____ Date:_____

Please return this form to Harmony Therapeutic Yoga LLC

spackard@HarmonyTheraYoga.com