# PHYSICAL THERAPY REFERRAL FORM

Citizens Choice Physiocare, Inc.

**Return Form To:**
PRINT *OR*
FAX- (901)767-5544

## PATIENT INFORMATION

Name: _____ DOB: _____
Address: _____
Diagnosis: _____
Medical Precautions: _____
Patient Phone: (Home) _____ (Mobile) _____
Primary Insurance: _____ Policy ID#: _____
Secondary Insurance: _____ Policy ID#: _____

## RECOMMENDED TREATMENT MODALITIES

□ Physical Therapy Evaluation and Treatment
□ Spinal Decompression
□ Post-Surgical Therapy
□ Sports injury Assessment
□ McKenzie Exercises
□ Posture/ Body Mechanic Education
□ Myofascial Release Therapy
□ Kinesio Taping
□ Gait Analysis/Training
□ Ultrasound
□ Manual Therapy
□ Functional Training
□ Therapeutic Exercises
□ Neuromuscular Re-Ed
□ Trigger Point Therapy
□ Electrical Stimulation ( TENS)
□ Strength Training
□ Wheelchair/Mobility Assessment

## FREQUENCY AND DURATION

Frequency: □ Therapist Discretion □ 1 x Week □ 2 x Week □ 3 x Week □ 5 x Week
Duration: □ Therapist Discretion □ 4 Weeks □ 6 Weeks □ 8 Weeks □ 10 Weeks

## REFERRING PHYSICIAN S INFORMATION

Physician's Address: _____
Office Telephone: ( _____ ) _____ Office Fax: ( _____ ) _____
I certify that the above Physical Therapy services are medically necessary and approved for the patient's Plan of Care.
Physician's Printed Name: _____ NPI#:_____
Referring Physician's Signature: _____ Date: _____

*Bringing Strength, Mobility & Function To You!*
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