

PHYSICIAN REFERRAL FORM

Patient Information:

- **Name:** _____ **DOB:** _____
- **Phone:** _____ **Insurance/Claim #:** _____

Clinical Indication (Reason for Referral):

- Low Back Pain / Sciatica
- Neck Pain / Headaches
- Disc Herniation/Radiculopathy
- Post-Surgical Rehab
- MVA / Personal Injury
- Workers' Compensation
- Pre-Natal / Post-Natal Care
- Extremity Complaint (Shoulder/Elbow/Wrist/Hand/Hip/Knee/Ankle/Foot)
- Other: _____

Services Requested:

- Chiropractic Evaluation & Treatment
- Medical Massage Therapy (97124)
- Radiographic Imaging (X-Ray)

Scan the code to access
this referral form

Referring Provider Information:

- **Provider Name:** _____
- **Office Phone:** _____
- **Fax for Reports** _____



"Progress reports and daily notes will be faxed back to the referring physician upon completion of the initial 12-visit block or upon patient discharge."