HUMPAL CHIROPRACTIC

PHYSICAL THERAPY REFERRAL

Date:______/______/__________

Patient Name:____

DOB:______/______/__________

Patient Phone Number: __________-__________-_______________

Patient Email: ____

Diagnosis/Reason for Referral:____

Medical Precautions:____

Other Requests:____

Frequency:

☐ Therapist Discretion ☐ 1x/Week ☐ 2x/Week ☐ 3x/Week ☐ 5x/Week

Duration:

☐ Therapist Discretion ☐ 4 Weeks ☐ 6 Weeks ☐ 8 Weeks ☐ 10 Weeks

Referring Physician Information:

Physician Name:____

Physician NPI:____

Physician Address:____

Office Telephone:____

Medicaid Patient's Only - Referring Clinic NPI :____

I certify that the above Physical Therapy services are medically necessary and approved by me.

Physician Signature: ____ Date:_____/______/________