



## PATIENT REFERRAL

Name:

Diagnosis: (ICD-9)

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Appointment Date:

Time:

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### CONSULT: EVALUATE & TREAT

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### SPECIALITY SERVICES:

- Functional Capacity Evaluation
- Fitness/Weight Loss Consultation
- Spine Program
- Balance/Vestibular
- Gait/Bike/Swim Assessment
- Sport Specific Program

### HELPFUL HINTS:

Bring your physician referral on your first visit  
Wear loose fitting shorts or tee shirts each visit

Insurance counseling available  
Expect each visit to last from 1 to 1.5 hours

*Please call to reschedule at least two hours in advance, if you cannot keep your appointment. Thank you!*

I certify that the above is medically necessary in the treatment of the above patient's medical condition.

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_

