FYZICAL® Therapy & Balance Centers

Experience the FYZICAL Difference!

Rehabilitation Referral

Major Insurance Plans Accepted

Patient Name:______________________________ Date:______________

Phone:______________ DOB:____________ ICD Code:____________________

Diagnosis:____

Special Instructions:____

____

☐ Evaluate and Treat at Therapist's Discretion

Physician Signature:____________________ Physician Name (print):__________________

Certification: I certify that this treatment is medically necessary and required for the above named patient.

Services Available

Balance Rehabilitation

- ☐ Vestibular Rehabilitation
- ☐ Balance Retraining
- ☐ Concussion Management
- ☐ Dizziness
- ☐ CD Posturography CDP
- ☐ Strengthening & Endurance

Orthopedic Rehabilitation

- ☐ Pre-Surgical Rehabilitation
- ☐ Post-Surgical Rehabilitation
- ☐ Soft Tissue Mobilization
- ☐ Joint Mobilization

Additional Services

- ☐ Fall Prevention
- ☐ Dry Needling
- ☐ Custom Orthotics
- ☐ Other:______________

Frequency: ☐ 1 ☐ 2 ☐ 3 ☐ 4 Days per Week

Duration:________ ☐ Weeks ☐ Months

☐ As recommended per PT evaluation

Please fax form and demographic sheet to 704-780-1108.

704-780-1108

704-780-1558

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