FYZICAL®
Therapy & Balance Centers

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REHABILITATION REFERRAL

Major Insurance Plans Accepted

Patient Name: _____ Date: _____

Phone: _____ DOB: _____ ICD Code(s): _____

Diagnosis: _____

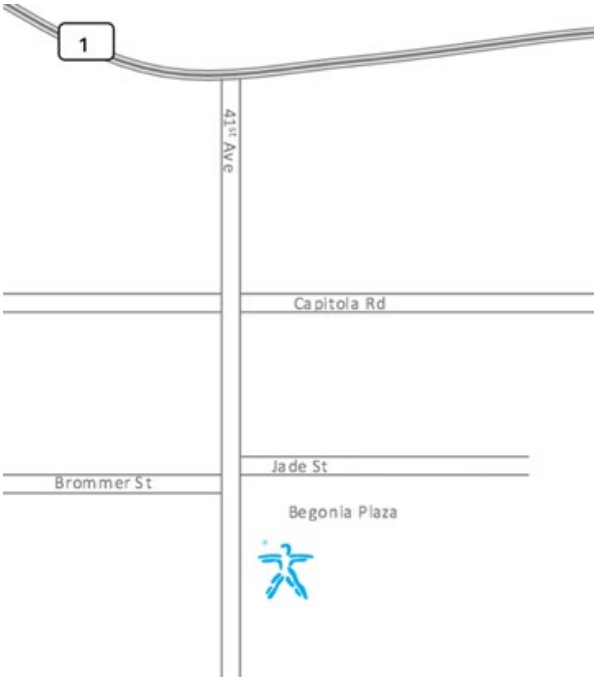
Special Instructions: _____

_____

☐ Evaluate & treat at physical therapist's discretion

Physician Signature: _____ Physician Name (Print): _____

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



Help your patients avoid an emergency room visit...
Send them to FYZICAL Therapy & Balance Centers for a free Fall Risk Assessment!