FYZICAL®
Therapy & Balance Centers

REHABILITATION REFERRAL

Major Insurance Plans Accepted

Patient's Name: _____ Patient's Phone: _____

Diagnosis: _____ Patient's DOB: _____

Provider's Name (Print): _____ Frq/Dur: _____

☐ EVALUATE & TREAT at the Therapist's Discretion

ORTHOPEDIC SERVICES

- ☐ Pre & Post Surgical Care
- ☐ Manual Therapy & Manual Traction
- ☐ Endurance & Conditioning
- ☐ Worker's Compensation
- ☐ Home Exercise Programs
- ☐ Sports Specific Training
- ☐ McKenzie Spine Program
- ☐ Pelvic Health

BALANCE SERVICES

- ☐ Vestibular Rehabilitation Therapy
- ☐ Balance & Gait Retraining
- ☐ Neuromuscular Re-Education
- ☐ Balance / Proprioception
- ☐ Falls Prevention
- ☐ Safety Overhead Support Systems
- ☐ Amputee Gait Training
- ☐ BPPV / Vertigo & Dizziness

Notes/Precautions: _____

REFERRING PROVIDER INFORMATION

Provider's Signature: _____ Date: _____

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