Gainesville Physical Therapy & Wellness , LLC

"Where People Matter and Results Count"

PHYSICAL THERAPY REFERRAL FORM

Patient name: ____

Diagnosis/CPT Code: _____________________________________

Date of Onset: ____

Surgery Date/Procedure: __________________________________

MRI/X-Rays performed? ☐ YES ☐ NO *If yes, please send results*

Lab Work performed? ☐ YES ☐ NO

Results: ____

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☐ Referral for Physical Therapy Evaluate and Treat Notes/Comments

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I certify that the patient is aware of his or her diagnosis and prognosis and that the treatment prescribed is medically necessary.

Physician's Signature: ____________________________________

Date: ____

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