



REFERRAL FORM

Patient Name: _____

Date of Referral: _____ Referring Physician: _____

Diagnosis: _____

Suggested frequency: Begin Therapy for _____ wks. Continue therapy for _____ wks.

Duration (circle one): Until program is complete Until next MD visit As per plan of care

Evaluate and Treat as indicated

- Evaluate and Treat
- Acute Muscular-Ligamentous Strain/Sprain
- Herniated/Bulging Disc (Acute)
- Acute Facet Sprain/Strain
- Chronic Pain with Deconditioning
- Post Surgical Rehab. Program/Protocol
- Functional Capacity Evaluation (FCE)
- Work Hardening
- Work Conditioning
- Ergonomic Assessment
- Vestibular Rehabilitation
- Wellness Program

We work with and pre-authorize all Worker's Compensation claims, Motor Vehicle Accidents, and legal cases (personal injury)

To download your paperwork visit our website www.camphysicaltherapy.com/paperwork

Locations:
Hyattsville
Laurel
Glenn Dale/Bowie
Parkville/Baltimore

Phone: (301) 853-0093 Fax: (301) 853-0096

Precautions/Comments/Additional Instructions: _____

Signature: _____