

Patient Name: _____

Date of Referral: _____ Referring Physician: _____

Diagnosis: _____

Suggested frequency: Begin therapy for _____ weeks Continue therapy for _____ weeks

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
- Vestibular Rehabilitation
- TMJ
- Functional Capacity Evaluation (FCE)
- Work Hardening
- Work Conditioning
- Ergonomic Assessment
- 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
Wheaton/Silver Spring

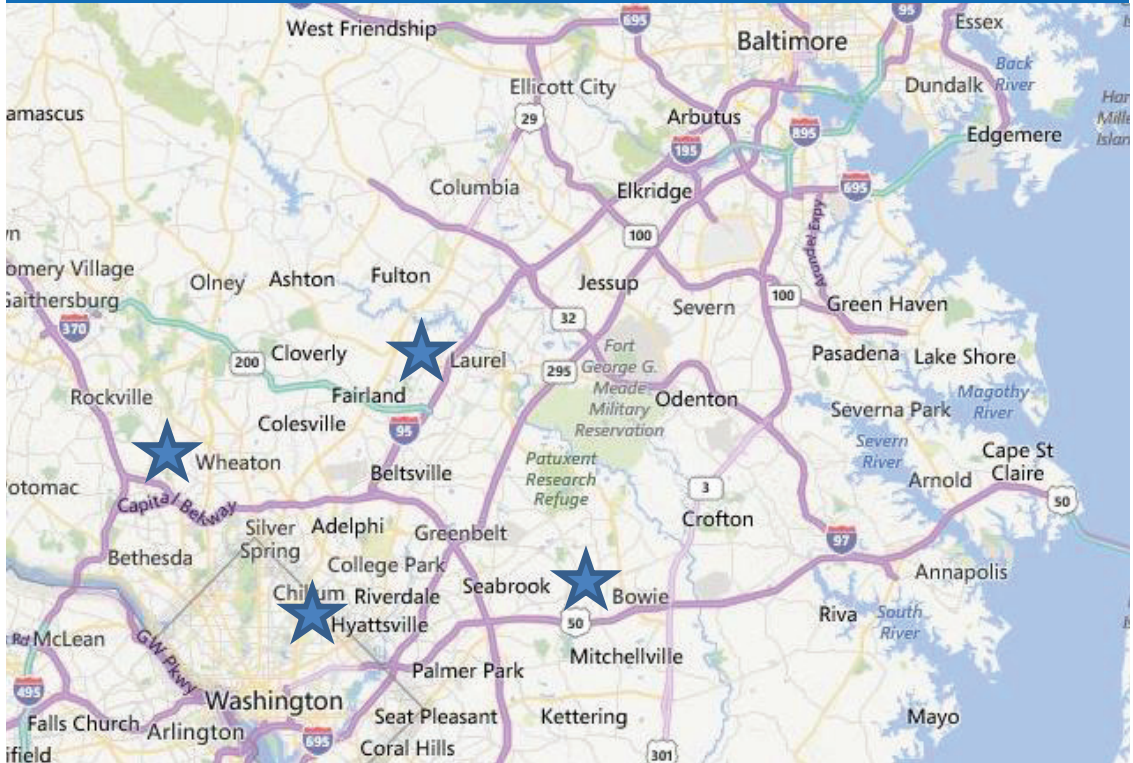
Phone: (301) 853-0093

Fax: (301) 853-0096

Precautions/Comments/Additional Instructions: _____

Signature: _____

OFFICE LOCATIONS



Hyattsville

3311 Toledo Terrace, Suite A-1
Hyattsville, MD 20782

 Prince George's Plaza Metro (Green Line)

 F4, 6

Wheaton/Silver Spring

2730 University Boulevard West, Suite 802
Wheaton, MD 20902

 Wheaton Metro (Red Line)

 34, 38, 48, C2, C4, Q1, Q2, Q4, Q5, Q6, Y2, Y7, Y8

Glenn Dale/Bowie

12150 Annapolis Road, Suite 305
Glenn Dale, MD 20769

 B24, B25

Laurel

14205 Park Center Drive, Suite 204
Laurel, MD 20707

 Z9, Z29