CAM
Physical Therapy and Wellness Services LLC.
"Where Wellness Is Our Function"

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
- ☐ Vestibular Rehabilitation
- ☐ TMJ
- ☐ Functional Capacity Evaluation (FCE)
- ☐ Work Hardening
- ☐ Work Conditioning
- ☐ Ergonomic Assessment
- ☐ Weight Loss Program
- ☐ 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
Silver Spring

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

Precautions/Comments/Additional Instructions: _____

_____

_____

Signature: _____

Maps to facilities on reverse side. Sé Habla Español!