Physician Referral for Chiropractic

Patient Name: ____ DOB: _____________________

Patient phone #: ____________________________________ ICD-10 code: ___________________

Diagnosis: ____

Surgical Procedures: ____

Imaging/Testing Results: ____

CHIROPRACTIC

Evaluate and Treat
Spinal Manipulation
Electrical Stimulation
Home Exercise Program
Other: _________________________________

Activator I
Myofascial Release
Hot Pack

Manual Traction
PRN Modalities
Cold Pack

SPECIALTIES

Physical Therapy

Chiropractic

Physician certifies that the prescribed therapy is of medical necessity.

Notes/Special Instructions: ____

Physician Name (Printed): ____

Physician Signature: ____ Date: ________________

Physician Phone #: ____________________________