SportsMED Physical Therapy

PHYSICAL THERAPY REFERRAL FORM

Please fax this form to location requested fax number provided below to request an appointment for your patient. We will contact your patient, schedule the appointment, and return the form to you with the appointment details.

REFERRING PHYSICIAN _____ NPI _____

PHONE _____ FAX _____

CONTACT _____

ADDRESS _____

PREFERRED CLINIC:

☐ **HUNTSVILLE CLINIC**
4715 Whitesburg Drive
First Floor
Huntsville, AL 35802
P: (256) 319-8500
F: (256) 319-8503
Mn-Fr: 7am - 6pm

☐ **MADISON CLINIC**
33 Hughes Road
First Floor
Madison, AL 35758
P: (256) 319-9327
F: (256) 319-9328
Mn-Fr: 7am - 6pm

☐ **WINCHESTER RD. CLINIC**
2139 Winchester Road NE
Suite B
Huntsville, AL 35811
P: (256) 425-5167
F: (256) 704-4320
Mn-Fr: 8am - 5pm

☐ **HAMPTON COVE CLINIC**
3101 Mountain Cove Circle
Suite B
Owens Cross Road, AL 35763
P: (256) 319-8500
F: (256) 319-8503
Mn-Fr: 8am - 5pm

TREATMENT PLAN:

Patient's Name: _____ Date of Birth: _____

Medical Diagnosis: _____

☐ Evaluate and Treat as Indicated ☐ Physical Therapy ☐ Occupational Therapy

☐ Hot/Cold Pack
☐ Ultrasound/Phonophoresis
☐ Therapeutic Exercise/Activity
☐ Gait Training
☐ Home Exercise Program
☐ Soft Tissue Mobilization
☐ Traction
☐ Work Conditioning
☐ Electric Stimulation/TENS
☐ Iontophoresis
☐ Coordination/Balance Training
☐ Mobilization/Manual Therapy
☐ R.O.M.: ____ Active ____ Passive

PRECAUTIONS, COMMENTS, AND SPECIFIC ORDERS:

_____

_____

EVALUATE AND TREAT: _____

Frequency of Visits (Times/Week): ____ 1 ____ 2 ____ 3 ____ 4 ____ 5

Duration (# of Weeks): ____ 1 wk ____ 2 wks ____ 3 wks ____ 4 wks ____ 6-8 wks ____ 10-12 wks

I certify that this treatment is medically necessary:

_____ _____

Physician Signature Date