RESULTS THERAPY

For Appointment, Please call or Fax
Tel: 651-288-9616 Fax:651-739-8452
email: admin@results-therapy.com
www.results-therapy.com

Referral Form

Date:_____

Patient Name:_____ DOB:_____

Patient Cell #_____ Home #_____ Work#_____

Insurance Company:_____ ID#: _____ Group#:_____

Adjustor: _____ Phone#:_____

☐ Personal Injury ☐ Workers Comp Claim#:_____

DOI:_____ Diagnosis: _____

Referring Dr:_____Phone#:_____Fax#:_____

Referring Dr. Signature:_____NPI#:_____

Physical Therapy

☐ Evaluate and Treat Up to _____visits

☐ Lower extremity Rehab

☐ Home Exercise Program

☐ Active / Passive ROM

☐ Spinal Decompression

☐ Pain Management

☐ _____

☐ Specific - please indicate below

☐ MedX Protocol

- ☐ Cervical
- ☐ Lumbar
- ☐ Cervical / Lumbar

Occupational Therapy / Rehabilitation

☐ Evaluate and Treat

☐ Return to Work Program

- ☐ Progressive Strengthening
- ☐ Posture / Body Mechanics

☐ Shoulder / Upper extremity Rehab

☐ Pain Management

☐ _____

Specialized Care

☐ Lymphedema Care

☐ ASTYM / Manual Therapy

☐ Dance / Performing Arts

☐ Cold Laser

☐ TMJ Care/Pterygoid Stripping

☐ Pregnancy - Back Care and exercise

☐ _____

Specific Requests:

_____

_____

_____

Please Fax Appropriate Radiology Reports & Relevant Office Notes Along With This Form

Please Fax Completed Referral Form To Results 651-739-8452

261 Ruth St. North, St. Paul, Mn 55119