



Hands On Pain Elimination

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Physical Therapy Referral

Patient's Name _____ DOB _____

Medical Diagnosis/ ICD.10: _____

Reason for Referral: _____

Patient Contact Info: Cell: _____ Home: _____

Treatment orders:

Evaluate and Treat as needed

Special Instructions: _____

Physician Signature _____ Date: _____

Physician's Fax Number _____

Please fax patient's history and physical findings in order to assure the most thorough treatment.

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