

PATIENT REFERRAL

Patient Name _____
 Date of Birth _____ Phone _____
 Email _____
 Insurance _____

Is this a work-related injury? ☐ Yes ☐ No

Employer _____

Case Manager Info _____

Evaluate and Treat

I certify by signature that the following treatment is medically necessary.

Dx _____

☐ PT ☐ OT (Hand Therapy)

Surgery _____ Treatment _____

Frequency _____ Duration _____

 Physician Signature

 Date

 Physician Name (Print)

☐ Cullman

Scott Jordan, PT, DPT
 Clinic Director

1634 Childhaven Road NE
 Cullman, AL 35055

P: (256) 775-4456

F: (256) 775-8845

☐ Florence

Daniel Eck, PT, DPT
 Clinic Director

3226 Florence Blvd
 Florence, AL 35634

P: (256) 275-3312

F: (256) 367-4122

☐ Gadsden ♀ 🤲

Jazma Dobbins, PT, DPT
 Clinic Director

Pelvic Health Practitioner

465 George Wallace Drive
 Gadsden, AL 35903

P: (256) 439-1550

F: (256) 439-1551

☐ Huntsville - Airport Road ♀

Josh Davis, PT, DPT
 Clinic Director

964 Airport Road
 Suite 10
 Huntsville, AL 35802

P: (256) 285-4250

F: (256) 285-4255

☐ Huntsville - Madison ♀

Michael Beuoy, PT
 Clinic Director

6485 University Drive NW
 Suite C
 Huntsville, AL 35806

P: (256) 513-8280

F: (256) 513-8286

☐ Jasper ♀ 🤲

Jacob Gates, PT, DPT
 Clinic Director

200 North Airport Road
 Suite 10
 Jasper, AL 35504

P: (205) 387-3266

F: (205) 387-3267

