TherapySOUTH

HANDS ON CARE, CLOSE TO HOME. and work!

www.therapysouth.com

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)*

◯ Auburn, AL

1530 East Glenn Avenue
Suite C
Auburn, AL 36830

P: (334) 502-7839
F: (334) 502-7879

◯ Opelika, AL

2701 Frederick Road
Suite 306
Opelika, AL 36801

P: (334) 610-0354
F: (334) 610-0355

◯ Columbus, GA

6053 Veterans Parkway
Suite 103
Columbus, GA 31909

P: (706) 786-6530
F: (706) 786-6535

◯ Montgomery, AL

8117 Old Federal Road
Montgomery, AL 36117

P: (334) 380-5920
F: (334) 380-5921

◯ Andalusia, AL

811 Western Bypass
Suite B
Andalusia, AL 36420

P: (334) 222-2620
F: (334) 222-2623

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