TherapySOUTH PATIENT REFERRAL

Patient Name _____

Date of Birth _____ Phone _____

Insurance _____ Group # _____

Policy # _____

Please fill out or attach demographics sheet

☐ **Eval and Treat**

☐ **PT** ☐ **OT** (Hand Therapy)

Frequency _____

Duration _____

Dx _____

Surgery _____

I certify by signature that the following treatment is medically necessary

_____ _____

Physician Signature *Date* *Physician Name (Print)*

BIRMINGHAM METRO

- **Alabaster/Pelham**
- **Bessemer/McCalla**
- **Calera**
- **Chelsea**
- **Clay/Pinson**
- **Crestline/Mtn Brook**
- **Fultondale**
- **Gardendale**
- **Greystone**
- **Helena**
- **Homewood**
- **Homewood - SoHo**
- **Hoover - S. Shades Crest**
- **Hoover - Hwy 31/I-65**
- **Hueytown**
- **Lakeview**
- **Leeds/Moody**
- **Liberty Park**
- **Patchwork Farms**
- **Pell City**
- **Riverchase**
- **Talladega**
- **Trussville/Roebuck**
- **Tuscaloosa**
- **Vestavia**
- **Woodlawn**

NORTH ALABAMA

- **Cullman**
- **Florence**
- **Gadsden**
- **Huntsville - Airport Rd**
- **Huntsville - Madison**
- **Jasper**

SOUTH ALABAMA

- **Andalusia**
- **Auburn**
- **Montgomery**
- **Montgomery - Carmichael Rd**
- **Opelika**

GEORGIA

- **Athens**
- **Columbus**

MISSISSIPPI

- **Gluckstadt**

Scan the QR code for information on all clinic locations