TherapySOUTH

SOUTH ALABAMA 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)*

☐ ***Andalusia***

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Clinic Director

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☐ ***Fairhope***

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SCAN THE QR CODE FOR INFORMATION ON ALL CLINIC LOCATIONS