TherapySouth

SOUTH ALABAMA PATIENT REFERRAL

Patient Name ______________________________

Date of Birth ____________ Phone ____________

Insurance ____________ Group # ____________

Policy # ____________

Please fill out or attach demographics sheet

☐ **Eval and Treat**

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