TherapySOUTH

SOUTH ALABAMA PATIENT REFERRAL

Patient Name _____

Date of Birth _____ Phone _____

Email _____

Insurance _____ Group _____

Policy # _____

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 _____

Surgery _____ Treatment _____

Frequency _____ Duration _____

_____ _____

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

☐ Andalusia

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Clinic Director

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Partner/Clinic Director

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☐ Foley

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☐ Saraland

Kristen Rather, PT, DPT
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SCAN THE QR CODE FOR INFORMATION ON ALL CLINIC LOCATIONS