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)*

☐ ***Auburn*** ♀ ✋

1530 East Glenn Avenue
Suite C
Auburn, AL 36830

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

☐ ***Columbus*** ♀

6053 Veterans Pkwy.
Suite 103
Columbus, GA 31909

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

☐ ***Montgomery (East)*** ♀ ✋

8117 Old Federal Road
Montgomery, AL 36117

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

☐ ***Montgomery - Carmichael Rd. (Midtown)*** ✋
(Industrial Rehab Center)

4142 Carmichael Rd, Suite B
Montgomery, AL 36106

P: (334) 839-5070
F: (334) 839-5075

☐ ***North Auburn***

1661 Shug Jordan Pkwy.
Suite 500
Auburn, AL 36832

P: (334) 203-4570
F: (334) 203-4575

☐ ***Opelika*** ♀

2701 Frederick Road
Suite 310
Opelika, AL 36801

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

☐ ***Andalusia*** ♀

811 Western Bypass
Suite B
Andalusia, AL 36420

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

✋ Hand Therapy Services (OT) Available
♀ Pelvic Health Therapy Available

SCAN THE QR CODE FOR ALL OF OUR CLINIC LOCATIONS