Arctic CHIROPRACTIC

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Physical Therapy Referral

Patient Name: _____

Patient DOB: _____ **Patient Phone #:** _____

Diagnosis Codes: _____ **Description:** _____

_____ _____

_____ _____

Treatment Modality:

Massage: □ Gentle, □ Systemic, □ Regional, □ Deep, □ Myofascial Release, □ Trigger Points, □ Transverse Friction Massage, □ Manual Therapy, □ Other: _____

Frequency and Duration:

Evaluate & Treat OR Start Date: _____ End Date: _____
_____ Times a week for _____ weeks

Instructions to Work on Specific Muscles:

□ Paraspinal, □ Scalenes, □ Sternocleidomastoids, □ Levator Scapulae, □ Trapezius, □ Rotator Cuff, □ Rhomboids, □ Intercostal, □ Latissimus Dorsi, □ Psoas, □ Glutes, □ Hamstring Group, □ Quad Group, □ Gastroc / Soleus, □ Quadratus Lumborum, □ Multifidi, □ Other: _____

Short and Long Term Goals:

_____

_____

Other Instructions:

_____

_____

TREATMENT IS MEDICALLY NECESSARY. Please treat the patient for the diagnosis indicated above, using the procedures that are within your scope of practice.

_____
Referring Provider Name Date: _____

_____
Signature of Referring Provider Providers NPI#:_____