Physical Therapy Referral Form

Refer to

Name of Healthcare Provider	Specialty
David Samuels	Physical Therapy
Email	**Preferred Phone Number**
david.samuels@example.com	123-123

Address	City	State	Zip Code
55 Example Street	New York	NY	0121

Patient Information

First Name	Last Name	Date of Birth
Hannah	Clifford	09/22/1995
Email		**Preferred Phone Number**
hannahclifford@example.com		000-999

Diagnosis of Referring Healthcare Practitioner
N/A

Medical History
Hannah seeking treatment for post-surgical back pain. Pain has been present for approx. 14 days. Surgerical procedure occurred 2 months ago.
Patient regularly taking anti-inflammatory medication.

Family History
N/A

Reason of Referral
Hannah is experiencing unexpected pain due to surgical procedure. Targeted strength exercises should reduce pain. Massage therapy may also be beneficial.

Additional Comment

Patient Insurance Information (If Applicable)

Insurance Carrier	Insurance Plan	Contact Number
Universal Health	A2	456-789
Policy Number	**Group Number**	**Social Security Number**
B28XY	2	200-155-876

Referring Clinician Information

First Name	Last Name	Specialty
Fiona	Phillips	General Practice
Email		**Preferred Phone Number**
fiona.phillips@example.com		000-123