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Referral/Prescription Form

TO: CHIROPRACTIC DIMENSIONS, LLP

Patient:____ DOB: ____/____/______ Phone: (____) _____-______

Diagnosis:____
____

ICD-9: 1)_________ 2)_________ 3)_________ 4)_________

Insurance Info (May send Copy of Card Front and Back):
Insurance Company: ________________________________ Claims/Benefit #: (____) ____-______
Insurance Company Address:____
Group #: ___________________________________ Member ID: _______________________________________

Procedures Requested:

______ Evaluation and Management (Sports Medicine, Pediatric, Chiropractic, Soft-Tissue)
______ Flexion/Distraction Therapy or Axial Distraction (Disc & Stenosis Cases)
______ Spinal and/or Extremity Manipulation
______ Soft-Tissue: Active Release Technique Graston Technique Trigger Point Therapy
______ Ultrasound Electrical Muscle Stim. Heat Icing Vasocryocompression(GameReady®)
______ Therapeutic Exercise (Functional Progressive Rehabilitation)
______ Gait Analysis
______ Core Stabilization Program
______ Radiographs (Views Requested:____)
______ Nutritional Evaluation and Treatment
______ Other:____

Frequency:____
Re-Evaluation Request Date:____

Precautions:____

Restrictions:____
____
____

Physician Signature:________________________________ Date: _________________
Clinic Name:_______________________________________Phone#:(____)____-______ Fax #:(____)____-______
(Every patient will be instructed in a home exercise program. You will always receive an initial evaluation and progress/discharge summary to keep you updated on our patient's progress.)