FYZICAL®
Therapy & Balance Centers

REHABILITATION REFERRAL

Major Insurance Plans Accepted

Patient's Name: _____ Patient's Phone: _____

Diagnosis: _____ Patient's DOB: _____

Provider's Name (Print): _____ Frq/Dur: _____

☐ EVALUATE & TREAT at the Therapist's Discretion

ORTHOPEDIC SERVICES

- Pre & Post Surgical Care
- Manual Therapy & Manual Traction
- Endurance & Conditioning
- Worker's Compensation
- Home Exercise Programs
- Joint Mobilization & Range of Motion
- Chronic Pain Management
- Pelvic Health Therapy

BALANCE SERVICES

- Vestibular Rehabilitation Therapy
- Balance & Gait Retraining
- Neuromuscular Re-Education
- Balance / Proprioception
- Falls Prevention
- Concussion Management
- Amputee Gait Training
- Epley Manuever (Manual)

AUDIOLOGICAL SERVICES

- Diagnostic Hearing Testing
- Tinnitus Evaluation/Management
- Videonystagmography (VNG)
- Computerized Posturography (CDP)
- Impedance Testing
- Hearing Aid Evaluation
- Cerumen Removal
- Custom Hearing Protection

Notes/Precautions: _____

_____

REFERRING PROVIDER INFORMATION

Provider's Signature: _____ Date: _____

Certification: I certify that this treatment is medically necessary and required for the above name patient.