

555 Building
555 W. Wackerly
Midland, MI 48642

East End Building
715 E. Main St.
Midland, MI 48640

Center City
324 S. Saginaw Rd.
Midland, MI 48640

Coleman Family Center
991 E. Railway
Coleman, MI 48618

THERAPY REFERRAL

Date: _____

Patient Name: _____

DOB _____ Phone # _____

Diagnosis: _____

PLEASE CHECK DESIRED TREATMENT PLAN:

- Evaluate & Treat
- Continue Current Rx

Modalities

- Hot / Cold Packs
- Electrical Stim
- TENS
- Ultrasound
- Phonophoresis
- Iontophoresis
- Traction - Cervical / Pelvic
- Anodyne Therapy
- Massage
- Splint
- Dry Needling

Services / Programs

- Manual Therapy
- Spine Rehab & Back Care
- Gait Training
- Balance / Falls Prevention
- Vestibular Rehab
- Urinary Incontinence
- Lymphedema Therapy
- Work Conditioning
- Sports Training
- Functional Capacity Evaluation

Special Instructions: _____

Schedule: Frequency _____ Duration _____ Wks.

I certify this treatment is medically
necessary.

Physician Signature