iCURE
PHYSICAL THERAPY
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# Patient Referral Form

(PDF form available at WWW.iCUREPT.COM)

## Referring Provider Information

Referring Provider/Clinic Name: _____
Phone: _____ Fax: _____
Provider Signature: _____ Date: _____

## Patient Information

Patient Name: _____
Date of Birth: _____ Phone: _____
Email (optional): _____ Insurance Provider: _____
Claim # (if applicable): _____ Date of Injury (if applicable): _____

## Diagnosis/ ICD-10 Code(s)

_____
_____

## Services Requested (Check all that apply)

- ☐ Balance / Fall Prevention
- ☐ Chronic Pain Management
- ☐ Core Strengthening Program
- ☐ Ergonomic / Postural Evaluation
- ☐ Fall Risk Screening
- ☐ Flexibility & Stretching Program
- ☐ Gait Training
- ☐ Geriatric Rehabilitation
- ☐ Joint Mobilization
- ☐ Kinesiology Taping
- ☐ Neurological / Vestibular Rehab
- ☐ Orthopedic
- ☐ Post-Pregnancy PT & Core Strengthening
- ☐ Postural & Body Mechanics Training
- ☐ Pre/Post-Surgical Rehab
- ☐ Soft Tissue Mobilization / ASTYM-like Techniques
- ☐ Spine Stabilization Program
- ☐ Sports Conditioning & Return to Play
- ☐ Sports Injury Rehab
- ☐ Work Conditioning / Return-to-Work
- ☐ Work-Related Injury (L&I)
- ☐ Modalities (e.g., E-stim, Ultrasound): _____

☐ Other: _____ _____

☐ **EVALUATE & TREAT** ☐ **CONTINUE PHYSICAL THERAPY**

## Additional Notes or Precautions

_____
_____

I confirm that the recommended therapy services are medically appropriate and necessary to support the patient's recovery and functional health.

Date: _____ Signature: _____

This form is intended for printing and physical submission, to ensure compliance and patient confidentiality, please DO NOT email this form or any medical referrals. Kindly complete, sign, and submit via fax, mail, or in person hand delivery. We strongly prefer referrals via fax or hand delivery to expedite care coordination.

Thank you for choosing iCURE Physical Therapy to assist in your patient's care. We will reach out to the patient promptly upon receiving this referral.