

Rehabilitation Management Specialists

Referral Form 484.223.1088 Phone * 610.433.7980 fax

Referring Doctor: _____ PH: _____

Patient Name: _____

DOB: _____ Date of Injury: _____

Diagnosis: _____

Insurance Name: _____

Insurance ID or claim #: _____

I am referring this patient for the following:

- 1)___ EMG Upper L R Lower L R Spinal area: _____
Other: _____
- 2)___ Pain Management Consult (MD)
- 3)___ Rehabilitation Consult & Prescription
- 4)___ Muscle Testing Upper Lower Spinal area: _____
- 5)___ FCE
- 6)___ Impairment Rating
- 7)___ Disability Evaluation
- 8)___ Second Opinion
- 9)___ Fitness Evaluation
- 10)___ Psychosocial Consult / Treatment
- 11)___ Biofeedback / Management
- 12)___ Injection Therapy
- 13)___ Back School

*“We Manage your clients physical and psychosocial needs so you can do what you are trained to do.....heal them”.
Each test or modality performed by specialists in that particular Field. Reports sent out within a few days, not weeks.*

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