WNC CHIROPRACTIC

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Referral Form

Patient Name _____ DOB_____

Phone Number _____

Diagnosis /Complaint _____

Secondary Diagnosis/Precautions _____

Imaging/Testing Results _____

Services

- ☐ Evaluate and Treat
- ☐ Telehealth Consultation
- ☐ Home Exercise Program
- ☐ _____

Recommended Therapies (Optional)

- ☐ Spinal Decompression
- ☐ Traction
- ☐ Electrical Stimulation
- ☐ Moist Heat/Ice
- ☐ Spinal Manipulation
- ☐ _____

Comments _____
_____

Referring Provider Info

Printed Name _____

Tel. _____ Fax. (for summary and updates) _____

Signature _____ Date_____