REFERRAL:

NAME:

DIAGNOSIS:

APPOINTMENT DATE: TIME:

○ CONSULT: EVALUATE & TREAT

I certify that therapy services for the above named patient are required, medically necessary and authorized by me.

PHYSICIAN'S SIGNATURE DATE

BRING THIS REFERRAL WITH YOU ON YOUR FIRST VISIT!

HELPFUL HINTS:

- COMPLETE YOUR PAPERWORK ONLINE AT *WWW.MYPROIMPACT.COM* PRIOR TO YOUR FIRST VISIT
- WEAR LOOSE FITTING SHORTS OR TEE SHIRT EACH VISIT

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