

8110 Cordova Road, Suite 107
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Physical Therapy Referral

Patient's Name: _____ Date: _____

Diagnosis: _____

Phone Number: _____ DOB: _____

Treatment Requested

- | | |
|---|--|
| <input type="checkbox"/> Back Program | <input type="checkbox"/> Neck Program |
| <input type="checkbox"/> Shoulder Program | <input type="checkbox"/> Knee Program |
| <input type="checkbox"/> Foot / Ankle Program | <input type="checkbox"/> Elbow Program |
| <input type="checkbox"/> Other _____ | |

Special Precautions / Instructions: _____

☐ Evaluate and Treat per protocol

Frequency: ☐ Daily ☐ 3x / wk ☐ 2x / wk ☐ 1x / wk

Duration: _____ Weeks

This Certifies Medical Necessity: _____

Physician's Signature

**We accept over 100
Healthcare Plans.**

Including:

Blue Cross Blue Shield
Coventry
Medicare
Humana
Tricare
Cigna

Workers Compensation

We also participate with many other smaller
insurance plans.

We will take care of all insurance precerts
and authorizations if it is required.

