

# PHYSICAL THERAPY FAX REFERRAL FORM

VALLEY CENTER FOR  
**Nerve Studies & Rehabilitation**  
**ERIC R. BECK, MD, PHD, FAAPMR**  
*Experienced, personalized care for effective results*

Fax to 256-382-1607. We will call patient to schedule their appointment. Form also available at [www.ericbeckmd.com](http://www.ericbeckmd.com).

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Referring Physician/Source \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

How do you prefer to receive your reports?  Fax  Mail  Both

## PATIENT

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_

Insurance \_\_\_\_\_ Policy No. \_\_\_\_\_

## REASON FOR REFERRAL

**Evaluation and Treatment**

**Frequency** \_\_\_\_\_ times/week

**Duration** \_\_\_\_\_ weeks

Diagnosis \_\_\_\_\_ Surgery Date (if applicable) \_\_\_\_\_

Special precautions \_\_\_\_\_

Physician signature \_\_\_\_\_ M.D./D.O.

**Workers Compensation**

Claim # \_\_\_\_\_

Case Manager \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Adjustor \_\_\_\_\_ Phone \_\_\_\_\_

Insurance Co. \_\_\_\_\_

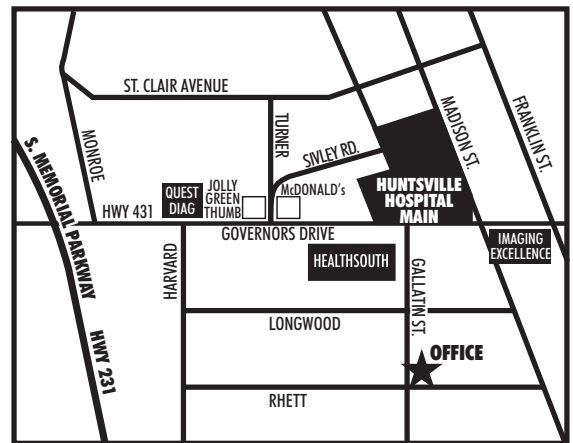
Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Email \_\_\_\_\_

Check preferred method to receive reports  Fax  Mail

Employer \_\_\_\_\_ DOI \_\_\_\_\_



## HUNTSVILLE

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