Physical Rehabilitation Group, LLC

Patient Referral

Patient Name: _____ Surgery Date: _____

DOB: _____

Diagnosis: _____

- ☐ Post-Operative Cervical Laminectomy Protocol
- ☐ Post-Operative Lumbar Laminectomy Protocol
- ☐ Post-Operative Cervical Fusion Protocol
- ☐ Post- Operative Lumbar Fusion Protocol
- ☐ Other

_____

Restrictions/Precautions: _____

_____

_____

_____

Frequency: _____ per week Duration: _____ weeks

***By my signature below, I certify the above indicated services are medically necessary.

Physician Signature: _____

Date: _____

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