SPINE AND SPORT BIOMECHANICAL REHABILITATION CENTER

Specializing in Biomechanical Correction Techniques through EVALUATION-EXERCISE-EDUCATION
2816 East Beltline Lane NE ● Grand Rapids, MI 49525 ● Phone (616) 361-1210 ● Fax (616) 361-8662

PATIENT REFERRAL FORM

KLEIMAN BCT BIOMECHANICAL CORRECTION TECHNIQUE™

DATE: _____

ATTENTION: _____

FAX NUMBER: _____

PLEASE HAVE PHYSICIAN SIGN AND RETURN PATIENT PRESCRIPTION

Patient Name: _____

DOB: _____ Phone Number: _____

Diagnosis (1) _____

(2) _____

(3) _____

(4) _____

Treatment Frequency & Duration

□ 3 – 4 / Week
□ 2 – 3 / Week
□ 1 – 2 / Week
□ ____ Weeks
□ Other _____
□ 6 Months
□ 3 Months
□ 2 Months
□ 1 Month

Physician Request

□ Evaluation – Treat – Modify
□ Evaluation – Treat – Prescribed
□ Evaluation – Consultation
□ Other_____

I certify that this is under my care and that treatment is medically necessary.

Printed Name: _____ **Physicians Fax:** (_____)_____

Physicians Signature: _____ **Date**: _____

NOTES: _____

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