ADVANCE PHYSICAL THERAPY
Certified Postural Restoration Center
77 South Elliott Road, Chapel Hill, NC 27514 Phone: 919.932.7266 Fax: 919.932.7250

Physical Therapy Referral Form

Patient Name: _____ DOB: _____

Patient Address: _____

Patient Phone: (Home) _____ (Mobile) _____

Primary Insurance: _____ Policy ID#: _____

Secondary Insurance: _____ Policy ID#: _____

Medical Diagnosis: _____ ICD-10 Code: _____

Medical Diagnosis: _____ ICD-10 Code: _____

Medical Diagnosis: _____ ICD-10 Code: _____

☐ Evaluate and Treat Onset Date: _____

☐ Resume Physical Therapy Plan of Care

Recommendations to include:

☐ Postural Restoration ☐ Manual Therapy ☐ Sports Medicine

☐ Schroth Method for Scoliosis ☐ Vestibular Therapy ☐ Post-Op _____

☐ Pediatric Physical Therapy ☐ Balance Training ☐ Other: _____

Precautions: _____

_____

Requested Frequency: _____ times/week x _____ weeks

Referring Physican's Name/Specialty: (Please Print) _____

Referring Physician's NPI #: _____

Physician's Address: _____

Office Telephone: (_____) _____ Office Fax: (_____) _____

For Medicaid Patient's Only: Referring CLINIC NPI # _____

I certify that the above Physical Therapy services are medically necessary and approved by me.

Referring Physician's Signature: _____ Date: _____