LVPTS

LAS VEGAS PHYSICAL THERAPY & SPORTS

Heal. Strengthen. Thrive.

7229 W Sahara Ave, Ste 105,
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PHYSICAL THERAPY REFERRAL FORM

1 PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ **Phone Number:** _____

Diagnosis: _____

Date of Surgery (if applicable): _____

2 TREATMENT REQUEST

☐ Evaluate and Treat **Other:** _____

Precautions: _____

Frequency and Duration: _____ Day/s per Week for _____ Week/s

3 INSURANCE / LIEN INFORMATION

A. INSURANCE

Insurance Name: _____

Member ID: _____

Claim Number: _____

B. LIEN / ATTORNEY INFORMATION

Law Firm Name: _____

Case Manager: _____

Case Manager Phone Number: _____

Case Manager Email: _____

4 REFERRING PHYSICIAN

Clinic Name: _____

Physician Name: _____

Physician Signature: _____ **Date:** _____

Healing starts today—let's achieve your goals together!

Call us to schedule your first appointment at (702) 586-2177